AWESOME Dental Stapleton

PATIENT INFORMATION – Please Print

Full Name ____ Preferred Name ________________________

Phone ____________________________________ DOB __________________ Age __________

Email __________________________________@____

Preferred Contact ____ Email or ____ Text or ____ Phone

Address ____

City ____________________________________ State _________ Zip _____________________

Sex ___M ___F ___T ___ Married ___ Single ___ Divorced ___Separated

Social Security Number _________________________________

Occupation _______________________________ Employer __________________________________

Emergency Contact – Name _____________________________ Phone __________________________

Other parties authorized to discuss your dental information? _______________________________________

Relationship ____

Who may we thank for referring you? ____

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

Person responsible for minor ____

Relationship to patient ___________________________________ Phone __________________________

Driver's License # __________________________ DOB _________________

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** or **Dislike** about your last dental visit? ____
(Please circle one)

____

____

MEDICAL HISTORY

Check if you have or have had any of the following

__ AIDS/HIV+	__ Blood Conditions	__ High Blood Pressure	__ Sinus Problems
__ Alcoholism	__ Bowel Disorder	__ High Cholesterol	__ Sexually Transmitted Disease (STD'S)
__ Allergies	__ Cancer	__ Kidney Disorder	
__ Anemia	__ Depression	__ Liver Disorder	__ Stroke
__ Anxiety Disorder	__ Diabetes	__ Lung Disease	__ Stomach Ulcer
__ Artificial Joint(s)	__ Eating Disorder	__ Migraines	__ Thyroid Disorder
__ Arthritis	__ Epilepsy	__ Osteoporosis	__ Tobacco
__ Asthma	__ Heart Condition(s)	__ Pacemaker	
__ Autoimmune Disease	__ Heart Disease	__ Recreational Drug Use	____________________
__ Bleeding Disorder	__ Hepatitis	__ Rheumatic Fever	

Other medical condition(s):____

Currently taking any medication? If yes please list:

____

____

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**) **If so, how many months? _____**

Nursing? (**YES** / **NO**) Taking birth control? (**YES** / **NO**)

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***

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***

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 Awesome Dental Stapleton 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. If you are more than 15 minutes late, we reserve the right to cancel or reschedule your appointment. 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 48 hour notice at our discretion.** This fee may also apply to a late arrival in the event we are unable to see a 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.

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SIGNATURE OF PATIENT DATE

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PRINTED NAME OF PATIENT