PATIENT MEDICAL HISTORY Please print legibly

Salutation	First Name	Last Name	M.I.
Home Phone ( )	Cell Phone ( )	Date of Birth	
Work Phone ( )	Fax ( )	Gender	
Home Address	City/State/Zip		
Employer Name	Occupation		
Employer Address	Social Security Number		
Referring Doctor	Family Dentist		
Family Physician	Family Physician Phone ( )		
Guarantor	Date of Last Physical Exam / /		
Home E-mail	Work E-mail		
Insurance Company	Address		
Subscriber's Name	Subscriber's Social Security Number		
Subscriber's DOB	Group #	Relationship	

Height: _____FT_____IN Weight: _____Lbs.

Preffered Pharmacy _____
Phone Number_____

	Yes	No	Don't Know
Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, please explain.			
Has there been any change in your general health within the past year? If yes, please explain.			
Are you under the care of a physician for a current problem? If yes, explain.			
Have you been hospitalized within the past 5 years? Please specify.			
Have you received therapy for alcoholism or drug addiction during the past 5 years?			
Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/ medications?			
Is there any condition concerning your health that the doctor should be told?			
Do you wish to speak to the doctor privately about anything?			
Have you had abnormal bleeding with previous extractions, surgery, or trauma?			
Have you ever required a blood transfusion?			
Have you ever had surgery and/or radiation for a tumor, growth, or other condition?			
Have you ever tested positively for HIV infection or AIDS? If so, state date diagnosed and treating doctor.			
Are you required to take antibiotics prior to dental treatment?			

Please continue

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

- ☐ High blood pressure
- ☐ Heart Murmur
- ☐ Joint prosthesis (hip, knee, etc.)
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Congenital heart disease
- ☐ Cardiovascular disease: heart attack, stroke or bypass
- ☐ Prosthetic heart valve
- ☐ Blood disorder
- ☐ Venereal disease
- ☐ Asthma
- ☐ Allergy to latex
- ☐ Low blood pressure
- ☐ Chest pain, angina
- ☐ Swollen Ankles, arthritis or joint disease
- ☐ Cardiac pacemaker
- ☐ Heart surgery
- ☐ Delay in healing
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ X-ray treatment or chemotherapy
- ☐ On a diet
- ☐ History of alcohol abuse
- ☐ Infectious mononucleosis
- ☐ Sinus Trouble
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Stomach Ulcers, Colitis
- ☐ Hepatitis, jaundice, Liver disease
- ☐ Kidney problems
- ☐ Psychiatric treatment

- ☐ Fainting spells, Seizures
- ☐ Epilepsy
- ☐ Cancer
- ☐ Temporomandibular Joint problem
- ☐ Low blood sugar
- ☐ Dialysis
- ☐ Irregular heart beat
- ☐ Contagious Diseases
- ☐ Bronchitis, Chronic cough
- ☐ Hay fever or sinus problems
- ☐ Problems with immune system
- ☐ Difficult breathing or other lung trouble
- ☐ Chronic Fatigue or night sweats
- ☐ History of drug abuse
- ☐ Wear contact lenses
- ☐ Gallbladder trouble

Are you taking any herbal medicine (i.e., St. John's Wort)? Circle one	YES	NO	DON'T KNOW
Have you ever taken the "fen-phen" diet? Circle one	YES	NO	DON'T KNOW
Do you have any disease, condition or problem not listed above? Specify.	YES	NO	DON'T KNOW

Are you taking bisphosphonates now or have you ever taken them in the past (Fosamax)? YES or NO
If Yes, How long were you on the medication? _____
If you are currently off the medication, how long ago did you discontinue? _____

Please continue:
Women only:

Possibility of pregnancy:	YES / NO	Nursing:	YES / NO
Estimated delivery date:		Taking birth control pills:	YES / NO

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of control.

EMERGENCY CONTACT INFO:

First name: _____ Last name: _____
Relation to patient: _____
Home number: _____
Work number: _____

Would you like to authorize release of your health records (to include medical history, treatment notes, x-rays, account information and entire record) to anyone other than yourself? If so please indicate name, phone number and relationship below.

YES or NO If yes, please name individuals: _____

Are you taking any medication or drugs? If yes, please list them below.

Start Date	Dosage	Frequency	Medication Prescribed

Patient or Guardian Signature _____ Date_____

Prescription Drug Monitoring Notification

By signing this form, you confirm that you have been notified that if you receive a prescription for a controlled substance (narcotic drug) from our office and fill that prescription at a pharmacy in Colorado, certain identifying prescription information, including the name of patient, will be entered into a secure database maintained by Colorado's prescription drug monitoring program. State law requires pharmacies to report information about controlled substance prescriptions filled to the prescription drug monitoring database.

This database is used to help prevent inappropriate uses of controlled substances – like fraud and diversion. The prescription drug monitoring program database contains only records related to controlled substances (narcotic drugs like painkillers, muscle relaxers and steroids). It does not contain records about other prescription drugs like antibiotics, antidepressants or any other category of prescription medication.

Only authorized individuals, like healthcare personnel that prescribe controlled substances and law enforcement under very limited circumstances, can access the database and only for tightly defined uses. As long as you are using controlled drugs appropriately, there shouldn't be reason for concern. If you do not want your information in the database, please ask your dentist to pre-scribe non-narcotic drug for you.

More information about Colorado's prescription drug monitoring program, including copies of individual prescription drug records stored in the database, can be obtained from Colorado State Department of Regulatory Agencies by calling 303-894-5957 or by visiting http://www.dora.state.co.us/pharmacy/pdmp/consumers.htm .

I have read and understand this notification.

Name _____Date_____

Office Financial Policy

Financial Policy

As a courtesy, if you have dental insurance we will bill your carrier, provide documentation, claim forms, radiographs, and treatment narratives. We request that you pay your co-payment at the time of service. We accept cash, checks, Care Credit, Visa, MasterCard, American Express, and Discover.

Those with dental insurance: We will estimate the portion your insurance is going to pay. Since this varies for each individual, usually 20 - 75% of the cost of the procedure is required at the time of service. We will bill your insurance for you. *Insurance companies routinely indicate that coverage verification does not guarantee payment. This means while we have done our best to estimate your out of pocket expense, when the insurance company actually processes the claim, the insurance payment may be less than expected. In some cases the dental insurance may even pay more than estimated.*

If your insurance pays more than the estimated amount, a refund check from this office will be mailed within 1 month from the date payment is received in this office.

If your insurance pays less than the estimated amount, you will receive a statement from this office. NOTE: *If your insurance company does not reimburse us after 2 submissions, you will be responsible for the remainder of the balance since we were unable to collect from them.*

Broken appointments: Many people see us because they are in severe pain and want to be seen immediately but a specific amount of time is reserved especially for your dental needs. We require at least 48 hours notice to avoid a $100.00 cancellation fee.

Print Name:_____

Sign Name:_____ Date_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Patient or Guardian Signature _____ Date_____