PATIENT INFORMATION

LAST NAME | FIRST | M.I.

PREFERS TO BE CALLED BY | MALE | FEMALE

BIRTH DATE | SOCIAL SECURITY NO.

SINGLE | MARRIED | PARTNERED | DIVORCED | WIDOWED

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO. | EMAIL

CELL

FULL TIME STUDENT

SCHOOL | GRADE

EMPLOYED

OCCUPATION | EMPLOYER'S NAME

ADDRESS | CITY

PHONE NO. | FAX NO.

YOUR SPOUSE

NAME

OCCUPATION | EMPLOYER'S NAME

ADDRESS | CITY

PHONE NO. | FAX NO.

PERSON FINANCIALLY RESPONSIBLE

NAME | RELATIONSHIP TO PATIENT

BIRTH DATE | SOCIAL SECURITY NO.

ADDRESS

CITY | STATE | ZIP

PHONE NO. | CELL

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

EMPLOYER NAME

INSURED'S NAME | RELATIONSHIP TO PATIENT

BIRTH DATE | INSURED'S SOCIAL SECURITY NO.

POLICY ID NO. | POLICY GROUP NO.

SECONDARY CARRIER

INSURANCE COMPANY

EMPLOYER NAME

INSURED'S NAME | RELATIONSHIP TO PATIENT

BIRTH DATE | INSURED SOCIAL SECURITY NO.

POLICY ID NO. | POLICY GROUP NO.

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?
NAME: RELATIONSHIP:

HOW DID YOU HEAR ABOUT US?

EMERGENCY CONTACT | **RELATIONSHIP TO PATIENT** | **ADDRESS** | **PHONE NO.**

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I hereby authorize payment directly to Appletree Dental of the group insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that an 18% APR may be added to my account per month. If required, I also understand a check of my credit history may be made. In the case of default of payment, I promise to pay any legal interest on the balance due, together with a collection fee of $35.00 and/or reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

6. I agree that the information on this page is correct to the best of my knowledge.

Patient or Responsible Party Signature | **Relationship to Patient** | **Date** | **Witness**

(PLEASE COMPLETE REVERSE SIDE)

PLEASE INITIAL

Appletree Dental's FINANCIAL POLICY

1) **Estimated co-payments are due at time of service.** Regardless of a divorce decree, Parent(s) and/or legal guardian(s) who bring children in for their visits are responsible for payment; parent(s) and/or legal guardian(s) must work out financial arrangements between themselves. _____

2) Patients are responsible for paying all charges not covered by their insurance plans and must pay within 30 days after insurance has denied payment to us. _____

3) All accounts that are 90 days past due will be sent to an outside collection agency with a $35.00 fee applied to your account. _____

4) **It is the patient's responsibility to know their insurance coverage**. In-office estimates are done as a courtesy to the patient, and are based on the coverage percentages given to Appletree Dental by your insurance company. Appletree Dental cannot be held liable for any stipulations or clauses in your plan which alter or adjust the estimated patient portion. We are always willing to submit pre-authorizations for proposed work at the request of our patients; *however* pre-authorizations **are not** a guarantee of payment by your insurance company. _____

5) **It is the patient's responsibility to make sure that any insurance information given to our office is correct and current.** Failure to provide such information will result in patient financial responsibility for all services provided. IF INCORRECT INSURANCE INFORMATION IS GIVEN and claims must be reprocessed, this may result in a reprocessing fee being added to your account. **This includes the omission of a secondary insurance carrier.** _____

6) If the patient fails to cancel a scheduled appointment with this office at least **24 hours** prior to the appointment, the patient can be charged a $75 fee for that missed appointment. It will not be billed to the patients insurance and will be the patient's personal responsibility. _____

7) Any personal check returned to the office for insufficient funds will result in the account balance being re-established and a $20 service charge added to your account. All subsequent visits will need to be paid with cash, credit card or certified funds. _____

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

_____

Patient or Responsible Party Signature Date

_____

Please print name Relationship to Patient

Patient Name: **Medical Alert:**

So that we may provide you with the best possible care please complete this dental/medical history form. All information is completely confidential.

1. **Reason for visit** today? Please describe_____

Are any of your **teeth sensitive** to:
- Hot or cold? Yes No
- Sweets? Yes No
- Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do your **gums bleed/hurt?** Yes No
Have your parents experienced gum disease or tooth loss? Yes No
Have you noticed any loose teeth or change in your bite? Yes No
Does food tend to become caught in between your teeth? Yes No

If yes, where? _____

Last **DENTAL: visit**_____**cleaning**_____**full mouth x-rays**_____**wisdom teeth** present? Yes / No, *year extracted* _____

Deeper cleaning (scaling/root planing)/got numb? Yes / No, *what year*_____ **Other** procedures?_____

2. Anything else about having **dental treatment** that you would like us to know? ☐ *Yes, please describe*_____ No
3. Have you been under the care of a **medical doctor** during the past two years? ☐ *Yes, please describe*_____ No

Physician's Name_____ Specialty_____ Phone_____

2. Have you ever been **hospitalized** or had a major operation? ☐ *Yes, please describe*_____ No
3. Have you ever had a serious **head or neck injury**? ☐ *Yes, please describe*_____ No
4. Are you taking any **medication/drugs**, including a regular dose aspirin or over-the-counter herbal medicines? ☐ ***YES - NOTE ON BACK*** No
   a. Have you taken any medication/drugs during the past two years? ☐ ***YES - NOTE ON BACK*** No
5. Do you or have you used **recreational marijuana?** ☐ *Yes.* Do you or have you used **prescribed medical marijuana?** ☐ *Yes*. No
   a. *If medically prescribed, please indicate the condition being treated?*_____
   b. *When was the last time you used marijuana (orally or inhalation)?*_____
6. Do you use tobacco? ☐ *Yes, please describe: what form, and how long?*_____ No
7. Do you use controlled/recreational substances? *Yes, please describe*_____ No
8. Are you aware of having an **ALLERGIC (or adverse) reaction** to any medication or substance? ☐ ***YES - NOTE ON BACK*** No
9. Indicate which of the following you have had, or have at present. *Please, circle "yes" or "no" to each item.*

A.I.D.S./HIV Positive Yes No	Cortisone Medicine Yes No	Hepatitis B Yes No	Renal Dialysis Yes No
Allergies Yes No	Diabetes Yes No	Hepatitis C Yes No	Rheumatic Fever Yes No
Alzheimer's Disease Yes No	Drug Addiction Yes No	Herpes Yes No	Rheumatism Yes No
Anaphylaxis Yes No	Easily Winded Yes No	High Blood Pressure Yes No	Scarlet Fever Yes No
Anemia Yes No	Emphysema Yes No	Hives or Rash Yes No	Shingles Yes No
Angina Yes No	Epilepsy or Seizures Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Arthritis/Gout Yes No	Excessive Bleeding Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Artificial Heart Valve Yes No	Excessive Thirst Yes No	Kidney Trouble Yes No	Spina Bifida Yes No
Artificial Joints (hip, knee, etc.) Yes No	Fainting or Dizzy Spells Yes No	Latex Sensitivity Yes No	Stomach/Intestinal Disease Yes No
Asthma Yes No	Frequent Cough Yes No	Leukemia Yes No	Stroke Yes No
Blood Disease Yes No	Frequent Diarrhea Yes No	Liver Disease Yes No	Swollen Ankles Yes No
Blood Transfusion Yes No	Frequent Headaches Yes No	Low Blood Pressure Yes No	Thyroid Disease Yes No
Breathing Problems Yes No	Genital Herpes Yes No	Lung Disease Yes No	Tonsillitis Yes No
Bruise Easily Yes No	Glaucoma Yes No	Mitral Valve Prolapse Yes No	Tuberculosis Yes No
Cancer Yes No	Hay Fever Yes No	Nervous/Anxious Yes No	Tumors or Growths Yes No
Chemotherapy Yes No	Heart Attack/Failure Yes No	Neurological Disorders Yes No	Ulcers Yes No
Chest Pain Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Venereal Disease (STD) Yes No
Cold Sores/Fever Blisters Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Yellow Jaundice Yes No
Congenital Heart Disease Yes No	Heart Trouble/Disease Yes No	Psychiatric/Psychological Care Yes No	
Contact Lenses Yes No	Hemophilia Yes No	Radiation Therapy Yes No	
Convulsions Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No	

10. Any disease, condition, or problem not listed? ☐ *Yes, please describe*_____ No
11. **WOMEN:** ***Pregnant*** or think you may be**?** Yes,_____months / No ***Nursing*****?** Yes / No Use ***birth control*** medications**?** Yes / No

I understand the information supplied is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature _____ Date _____

Dentist Signature_____ Date_____

Patient Name: **Medical Alert:**

Current Medications, Drugs, or Pills

Name	Amount	Frequency	Purpose	Last Taken

Medication or Substance ALLERGIC To

Name	Reaction	Date of Reaction

appletree dental

Phone: (720) 872-2892 Fax: (720) 872-2894

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Appletree Dental to use and disclose my protected health information for the following purposes:

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

In addition, I authorize Appletree Dental to disclose or **speak** about my protected health information (i.e. care, test results, account, appointment and premedication reminders) with the following **person(s)**:

1. _____
   Name Relationship

2. _____
   Name Relationship

Secondly, I authorize Appletree Dental to **leave details** regarding my protected health information (i.e. care, test results, account, appointment and premedication reminders) **on a voicemail** at the following number(s):

1. _____ work / cell / home

2. _____ work / cell / home

I have also been informed of and given the right to review and secure a copy of the 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 that the practice reserves 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 the 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 health care operations, but that you are not required to agree to these requested 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 revoke this consent is not affected.

Patient Name (Please Print) _____

Signature _____ Relationship to Patient _____ Date _____

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)_____