PATIENT REGISTRATION FORM

(This information is necessary for our files and your health and will be considered **CONFIDENTIAL**)

Last Name _____ First _____ Mi _____ M F

I prefer to be called: _____ Birthday: ___/___/___ Age: _____ Single Married Divorced

Social Security #: _____ Drivers License#: _____ Widowed Separated

Home Address: _____
Street City State Zip

Home Phone #: ( ) _____ Work Phone #: ( ) _____ Ext.: _____ Cell #: _____

Whom may we Thank for referring you? _____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____
Street City State Zip

If patient is a student-Name of school: _____

Neighbor or Relative not living with you

His/Her Name: _____ Relation: _____ Home Phone #.: ( ) _____

Address: _____ Work Phone #.: ( ) _____
Street City State Zip

Person Responsible for Account if other than Yourself

Name: _____ Relation: _____ Home Phone #.: ( ) _____

Employer: _____ Work Phone #: _____ Ext.: _____ Driver's License #: _____

Billing Address: _____
Street City State Zip

Spouse/Parent Information

Name: _____ Birthday: ___/___/___ Social Security #.: _____

Employer: _____ Work Phone #: ( ) _____ Ext.: _____ Driver's License #: _____

Dental Insurance Information

Primary Insurance

Insurance Co. Name: _____ Phone #: ( ) _____ Group#: _____

Insurance Co. Address: _____
Street City State Zip

Insureds' Name: _____ SS#: _____ Insureds' Birthday.: ___/___/___ Relation: _____

Insureds' Employer: _____ Employer Address: _____
Street City State Zip

Secondary Insurance

Insurance Co. Name: _____ Phone #: ( ) _____ Group#: _____

Insurance Co. Address: _____
Street City State Zip

Insured's Name: _____ SS#: _____ Insured's Birthday.: ___/___/___ Relation: _____

Insured's Employer: _____ Employer Address: _____
Street City State Zip

PATIENT RESPONSIBLE FOR FEES: I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine. Unless prior special arrangements are made, accounts are to be paid within 30 days of the date on which examinations are provided. I hereby authorize that the payment from any insurance company due me be paid directly to the working practice In the event of default in payment patient or party responsible for fees agree to pay any and all costs of suit, collection and attorney's fees.

By signing below I consent to the dental treatment provided by this practice. The information provided is accurate to the best of my knowledge.

Signature - Patient or Responsible Party _____ Date _____

HEALTH QUESTIONNAIRE

MEDICAL HISTORY

Name of Physician_____ Phone: _____

Your current physical health is: GOOD FAIR POOR

Are you currently under the care of a physician? Y N Please explain: _____

Are you taking any prescription/over the counter drug(s)? Y N Please explain: _____

Please list each one: _____

Have you ever had any serious illness or operation? Y N Please explain:_____

DO YOU HAVE TO BE PREMEDICATED BEFORE DENTAL TREATMENT? Y N **HAVE YOU EVER TAKEN PHEN-FEN? Y N**

IF SO, HAVE YOU CONSULTED YOUR M.D. REGARDING HEART CONDITION. Please explain: _____

FOR WOMEN

Are you taking birth control pills? Y N Are you pregnant? Y N Are you nursing? Y N

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	N	Heart Attack/Stroke	Y	N	High or Low Blood Pressure	Y	N	Ulcers
Y	N	Cancer/Chemotherapy	Y	N	Fever Blister	Y	N	Congenital Heart Defect
Y	N	Heart Murmur	Y	N	Severe/Frequent Headaches	Y	N	Radiation Treatment
Y	N	Rheumatic Fever	Y	N	Cardiac Pacemaker	Y	N	Asthma
Y	N	Heart Surgery/Pacemaker	Y	N	Psychiatric Problems	Y	N	Difficulty Breathing
Y	N	Shingles	Y	N	Epilepsy/Seizures/Fainting	Y	N	Hospitalized for any reason
Y	N	Mitral Valve Prolapse	Y	N	Diabetes	Y	N	Hepatitis
Y	N	Kidney Problems	Y	N	Drug/Alcohol Abuse	Y	N	Blood Transfusion
Y	N	Artificial Bones/Joints	Y	N	Venereal Disease	Y	N	Emphysema
Y	N	Artificial Valves	Y	N	Hemophilia/Abnormal Bleeding	Y	N	HIV+/AIDS
Y	N	Sinus Problems	Y	N	Glaucoma	Y	N	Anemia
Y	N	Tuberculosis (TB)	Y	N	Colitis	Y	N	Arthritis

Please list any medical condition(s) that you have ever had: _____

Are you allergic to any of the following drugs or materials?

Y	N	Penicillin	Y	N	Tetracycline	Y	N	Aspirin
Y	N	Erythromycin	Y	N	Codeine	Y	N	Antibiotics
Y	N	Sulfa Drugs	Y	N	Latex	Y	N	Other

Please list any other drugs that you are allergic to:_____

MEDICAL HISTORY

Previous Dentist_____ Phone: _____

Dental Complaint at this moment? _____

Have you ever had any unfavorable reaction from a local anesthetic? _____

Have you ever had any serious trouble associated with any previous dental treatment? _____

Explain: _____

How long since last dental X-Rays of your entire mouth? _____ How long since last dental treatment? _____

Do you have or do you use any of the following?

Y	N	Bleeding gums	Y	N	Complications from extractions	Y	N	Water jet device
Y	N	Food impaction	Y	N	Periodontal (gums) treatment	Y	N	Fluoride supplements
Y	N	Clenching or grinding	Y	N	Orthodontic treatment	Y	N	Fluoride treatments
Y	N	Bad breath	Y	N	Cigarettes, pipe or cigar smoking			
Y	N	Unpleasant taste	Y	N	Dental floss			

CONSENT FOR TREATMENT: I hereby authorized to the dentist(s) in charge of the care of the patient whose name appears on this form to administer any treatment, or to administer such anesthetic, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such dental operations or procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Signed _____ Date_____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

AAA HEALTH CENTERED DENTISTRY PC
FINANCIAL POLICY

We are glad you have entrusted our office with your dental health. To provide you with quality, timely care, our patients need to understand our financial policy.

Statements: Statements showing all procedures including any procedures that your insurance company normally covers at 100% are sent monthly, or as Benefit Statements are processed. Please note your outstanding balance is due upon receipt of your statement, if payment is not received by the 20th of each month following the first billing cycle, there will be a late charge of $5.00 or 5% of the minimum payment, which ever is greater. If there is a balance on your account after 60 days, we will charge your account at a periodic rate of 1.25% per month (ANNUAL PERCENTAGE RATE OF 15%). AAA Health Centered Dentistry is a participating provider with Care Credit. Monthly payment plans are available with Care Credit, upon approval by Care Credit. Please ask our staff if you are interested in more information.

Non-Insurance: Payment is due at the time of service, unless financial arrangements are made with the office personnel. Non-insured patients are eligible for a 5% discount on any services over $500.00, if paid in full at the time of service.

Insurance: We encourage you to become familiar with your policy's exclusions, deductibles and required co-payments. As a courtesy to our patients, we will provide the processing of your **primary coverage** insurance claims. Insurance is a contract between you and your insurance company. We are not a party to this contract. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your benefits and eligibility. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient/responsible party and that he or she is personally responsible for payment of all dental services. **We cannot bill your insurance company unless you give us your insurance information. At your first visit if we do not have the insurance information, we will give you a statement to submit to your insurance company and payment will be required at the time of service. All estimated co-pays, deductibles and non-covered portions of dental procedures are due at the time of service. If your insurance has not paid within 60 days, all charges will need to be paid by the patient or responsible party. Secondary insurance claims are the responsibility of the patient or responsible party.**

Missed Appointment Fee: Missed appointments are (at our discretion) charged at the rate of $50.00. Missed appointments are not only an inconvenience to our office but also do not allow other patients the opportunity to fill the appointment, therefore; Patients with 3 missed appointments may be asked to transfer their records to another doctor.

Late Cancellations: 48 hour notice is required for appointment cancellation. Late cancelled appointments are not only an inconvenience to our office but also, may not allow other patients the opportunity to fill the appointed time. Patients with a pattern of Late Cancellations may (at our discretion) be charged a $45.00 missed appointment fee, and if the pattern continues may be asked to transfer their records to another doctor.

Past Due Accounts: Necessary steps will be taken to collect this debt; you are responsible for all costs incurred to collect the debt.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Workers Compensation: Written approval/authorization by your employer and/or worker's compensation carrier is required prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Effective Date: Once signed, you agree to all of the terms and conditions contained herein.

Returned Checks: There is a $25.00 charge for each returned check.

Release: I hereby authorize AAA Health Centered Dentistry to release information to my insurance company, to the extent of facilitating payment of claims incurred with this office. I further authorize payment directly to AAA Health Centered Dentistry insurance benefits otherwise payable to me.

Patient's Name:_____ Date: _____

Responsible Party's Signature_____Relationship to Patient:_____

AAA Health Centered Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{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)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

AAA Health Centered Dentistry

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 12/16/2002, 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, $0 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.

Contact Officer: Lynn Wilson, Office Manager

Telephone: 303-776-6021 Fax: 303-772-7281 E-mail: dentalbynature@comcast.net

Address: 2130 Mountain View Avenue, Unit 205, Longmont, CO 80501