2120 17th Ave
Longmont, CO 80501
Tel: (303) 776-6021

PATIENT INFORMATION

Name____ I prefer to be called_____________________ Male Female

Date of Birth _____/_____/_____ Social Security # (required if insurance funded) _______-______-________

Home Address____

Street City State Zip Code

Mailing Address (IF DIFFERENT) ____

Street City State Zip Code

Home Phone # (_____) _________________ Work #(_____)_________________ Cell/Pager #(_____)__________________

If you are a new patient how did you hear about us? ____

PERSON RESPONSIBLE FOR ACCOUNT - IF OTHER THAN PATIENT

Spouse - Name of Spouse_____________________________ Parent - Parent Name___________________________

Mailing Address (IF DIFFERENT) ____

Street City State Zip Code

Date of Birth _____/_____/_____ Social Security # _______-______-_______

INSURED INFORMATION - IF OTHER THAN PATIENT PLEASE PROVIDE

Name of Insured____ Relationship of Insured Spouse Parent

Insured Social Security Number _______-_____-_______ Insured Date of Birth _______/_______/_________

INSURANCE INFORMATION

Name of Insurance Company____________________________________ Insurance Phone (_____) ____________________

Address of Insurance Company____

Street City State Zip Code

Group #_________________________ Plan_____________________________ Union #_______________________________

Employer ____ Employer Phone # (_____) ___________________

Employer Address____

Street City State Zip Code

EMERGENCY CONTACT - NAME _____________________________________

Home Phone # (_____)_______________ Work #(_____)_______________ Cell/Pager #(_____)______________________

Home Address____

Street City State Zip Code

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MEDICAL HISTORY

Patient Name: ____ **Date:** _______________________

Physician's Name and Address: ____

Has your medical Dr. informed you that a antibiotic pre-medication is needed before your dental appointment: YES NO

NEW PATIENTS PLEASE CALL OUR OFFICE AND INFORM STAFF PRIOR TO YOUR APPOINTMENT (303) 776-6021

Are you currently in pain? If so, please describe ____

How is your general health? ____

Recent serious illness? ____ Hospitalized?___________________________

Please list current drugs, medications, or supplements being taken: ____

____

Please list allergies to drugs or medications: ____

Concerning diet: Do you have any food or herb allergies? ____

Do you have any allergies to metals in jewelry? ____

Do you have or have you had: (Please check all that apply)

____ Heart Trouble	____ Stroke	____ Lung Disease	____ High Blood Pressure
____ Chest Pain	____ Hepatitis	____ Low Blood Pressure	____ Diabetes
____ Cancer	____ Heart Murmur	____ Excessive Thirst	____ Artificial Joints
____ Rheumatic fever	____ Seizures	____ Hypoglycemia	____ Other Heart Problems
____ Kidney Trouble	____ Hemophilia	____ Arteriosclerosis	____ Ulcers
____ Shortness of Breath	____ Allergies	____ Addictions	____ Asthma
____ Cold Sores	____ Tuberculosis	____ Swelling Extremities	____ Sinus Problems
____ Fainting	____ Dizziness	____ HIV Positive	____ AIDS Positive
____ Vegetarian Diet	____ Thyroid Disease	____ Chronic Fatigue	____ Fibromyalgia
____ Lyme's Disease	____ Lupus	____ Muscular Sclerosis	____ Arthritis
____ Parkinson's Disease			

Do you snore? ________ Do you have sleep apnea? ________

Women Only: Are you pregnant? ______ Are you breastfeeding? ______

Patient Signature: ____ Date: ____________________

Doctor's Signature: ____ Date: ____________________

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DENTAL HISTORY

Patient Name:____**Date**: _______________________

Primary reason for this dental appointment: ____ Examination ____ Emergency ____ Consultation

The following information is important, because we want to be thorough in understanding you and your present or future problems. This way, we may better serve your oral health needs. Our objective is to help you to be well in the future, as well as now. *Please Circle*

Do you have a specific dental Problem? Describe____ Yes No

Do you have dental examinations on a routine basis? Last Visit_____________________________________ Yes No

Have you been satisfied with your past dentistry? _______________________________________ Yes No

Previous Dentist:______________________________City____

Do you think you have active decay or gum disease? Yes No

Do you have: Bad Breath ______Bad Taste _______ When?_______________________________________ No

Do you brush and floss on a regular basis?_____ How often? ______________________________________ Yes No

Have you had your gums treated (periodontal therapy)? When?____________________________________ Yes No

Tooth sensitivity? What and where? ____ Yes No

Are you aware of grinding or clenching your teeth? When?____ Yes No

Do you have: Noises when opening or closing your jaw?____ Yes No

Do you smoke cigarettes? ____ Chew tobacco?____ Drink Coffee?_____ Cups per day______ No

Do you eat:	Daily	X/Week	X/Month	
Candy	____	_____	_____	Yes No
Cookies, cake etc.	____	_____	_____	Yes No
Soft drinks	____	_____	_____	Yes No
Red Meat	____	_____	_____	Yes No
Chicken, turkey, fish	____	_____	____	Yes No
Fresh fruit	____	_____	_____	Yes No
Vegetables	____	_____	_____	Yes No

Do you take vitamin or mineral supplements? Yes No

What kind?____Reason (s) ?____

1. Why are you here?
2. Tell me what you do to clean your teeth at home? How often do you brush? Floss?
3. Do you have periodontal problems? Have you had periodontal therapy? Do your gums bleed? When?
4. Do you have any teeth that are sensitive to hot, cold or air? Pressure?
5. Have you noticed any spots or stains on your teeth? Any concerns about appearance?
6. Does tooth loss tend to run in your family? Does that concern you? Are you missing any teeth?
7. Do you have concerns about mercury amalgam fillings?

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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, whichever 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. Noninsured 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 **$50.00** 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.

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

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

Release: I hereby authorize Dental By Nature 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 Dental By Nature insurance benefits otherwise payable to me.

Patient's Name: ___________________________________ **Date:** ____________________________

Responsible Party's Signature: ___________________________________

Relationship to Patient: ___________________________________

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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)

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Dental By Nature

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.

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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 Kris Waage

Telephone: 303-776-6021 Fax: 303-772-7281 E-mail: dentalbynaturedds@gmail.com

Address: 2120 17th, Longmont, CO 80501

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