Welcome to DHC! :)

Welcome to our office. We appreciate the confidence you have placed in us to provide you with oral health services. To assist us in serving you, please complete the following form. The information provided is very important to your overall health. If you have any questions, please don't hesitate to ask.

Dental Health Colorado

1. NEW PATIENT INFO

Personal Information

Name _____ DOB / / Age Sex
First *Middle* *Last*
Address _____ City _____ State Zip

Cellphone Home Phone Email

Employer Work Phone

Driver's License State SSN – –

Responsible Party *(leave blank if same as information above)*

Name _____ DOB / / Age Sex
First *Middle* *Last*
Address _____ City _____ State Zip

Cellphone Home Phone Email

Employer Work Phone

Relationship to patient SSN – –

Dental Insurance *(please provide card so we may scan it into your patient file)*

Insurance Provider Group Name

Subscriber DOB / / ID #:
First *Middle* *Last*
Group ID Phone Number

Address City State Zip

Secondary Insurance Group Name

Subscriber DOB / / ID #:
First *Middle* *Last*
Group ID Phone Number

Address City State Zip

Medical Insurance *(please provide card so we may scan it into your patient file)*

Insurance Provider Group Name

Subscriber DOB / / ID #:
First *Middle* *Last*
Group ID Phone Number

Address City State Zip

CONTINUED....

Patient Initials _____

Secondary Insurance Group Name

Subscriber DOB / / ID #:
First *Middle* *Last*
Group ID Phone Number

Address City State Zip

Emergency Contact(s)

Name Phone Relation
First *Middle* *Last*

Name Phone Relation
First *Middle* *Last*

How Did You Hear About Us? *(please select all that apply)*

Online Source?

Friend Name?

Doctor Name?

Other Details?

CONTINUED....

Patient Initials _____

2. PATIENT HEALTH HISTORY

Oral Health History

Date of Last Dental Visit ___/___/___ Date of Last Medical Visit ___/___/___

Name of Previous Dentist _____ Phone Number _____

***** PLEASE ANSWER (**Y**)ES OR (**N**)O TO THE QUESTIONS BELOW *****

Are you apprehensive about oral treatment? _____ If yes, please explain (minimal, moderate, severe, etc.) _____

_____

If 18 years of age, or older, are you interested in CBD to alleviate your anxiety during your visit? Yes No

Have you had problems with previous oral treatment? _____ How often do you brush? _____ Floss/Waterpick? _____

Do you gag easily? _____ Does your jaw make noise? _____

Do you wear dentures/partial? _____ Do your jaws ever feel tired? _____

Does food catch between your teeth? _____ Do you clench or grind your jaws? _____

Do you have difficulty chewing your food? _____ Does your jaw ever lock? _____

Do you only chew on one side of mouth? _____ Does it hurt when you open wide? _____

Do you avoid brushing any side due to pain? _____ Do you have earaches or ear pain? _____

Do your gums bleed easily? _____ Do you have headaches when awaking? _____

Do your gums feel sore/tender? _____ Does jaw pain affect your appetite, sleep, daily routine or other activities? _____

Have you noticed slow healing sores in mouth? _____ Does jaw pain cause depression? _____

Do you take fluoride supplements? _____ Do you take medication for pain/discomfort (pain reliever, muscle, relaxants)? _____

Do your gums bleed when flossing and/or waterpicking? _____ Do you have temporomandibular jaw (TMJ) disorder? _____

Are you unhappy with appearance of teeth? _____ Do you have pain in face/cheeks? _____

Do you want to save your teeth? _____ Do you have an uncomfortable bite? _____

Do you want complete oral health care? _____ Have you had trauma to jaw? _____

Do you use tobacco? _____ Are you a habitual gum chewer? _____

Do you have any disease, condition or problem not mentioned above? Please explain _____

_____

Please add anything else you would like us to know about _____

_____

Please list all medications you are taking (use additional sheet if necessary) _____

_____

CONTINUED....

Patient Initials _____

Medical Health History

Primary Care Physician (PCP) _____ Specialty (if not PCP) _____

Practice Name _____ Preferred Hospital System _____

Physician/Practice Address _____ City _____ State _____ Zip _____

How would you describe your general health? Good Fair Poor

Are you currently being treated or have been treated within the last year by a physician? If yes, please explain _____

_____

Have you had a major illness or been hospitalized within the last 5 years? If yes, please explain _____

_____

Please check if you are sensitive or allergic to any of the following:

____Penicillin	____Demerol	____Other Antibiotic
____Codeine	____Novocaine or Other Dental Anesthetic	____Aspirin
____Barbiturates (sleeping pills, sedatives)	____Foods (please explain)_____	
____Sulfa Drugs	____Other (please explain)_____	

Are you on a special diet, or have dietary restrictions? If yes, please explain _____

_____

Do you drink alcoholic beverages? Yes No

Please check if you have ever had any of the following:

____Heart Disease	____Nervous Disorder or Psychiatric Care	____Kidney Disease or Infections
____Heart Attack	____Ulcers	____Diabetes
____Stroke	____Hepatitis, Liver Disease or Jaundice	____Blood Disorders (Anemia, Leukemia, etc.)
____Heart Murmur	____Artificial Transplants or Implants (Pacemaker, Heart Valve, Hip Joint, etc.)	
____Hemophilia	____Rheumatic Fever	____Venereal Disease
____Scarlet Fever	____Eye Disease (Glaucoma, Cataracts, etc.)	____Skin Disease
____Abnormal Blood Pressure (high/low)	____Ear Trouble	____X-Ray, Radium or Cobalt Treatment
____Severe or Frequent Headaches	____Sinus Trouble	____Tumors or Malignancies
____Fainting Spells	____Lung Disease (T.B., Emphysema, etc.)	____AIDS
____Epilepsy	____Arthritis	____Other _____

WOMEN ONLY

Are you Pregnant? No Yes Delivery Date _____

Taking oral contraceptives? No Yes

Are you or have you passed through Menopause? No Yes

Is there any other information about your health which might be important for us to know? If yes, please explain _____

_____

CONTINUED....

Patient Initials _____

I understand the above information (Sections 1 and 2) is necessary to provide me with oral 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 oral care and/or medical care provider or agency, which may release such information to you. I will notify DHC of any change in my health or medication.

Print Patient Name _____

Patient/Guardian Signature X _____ **Today's Date** ___/___/___

Relationship to Patient _____

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Health History and Notes Reviewed By Clinical Staff

Dentist _____ **Date** ___/___/___

Hygienist _____ **Date** ___/___/___

3. LEGAL STATEMENTS

Releases

- I authorize DHC dentists and/or hygienists to perform diagnostic procedures and/or treatment as may be deemed necessary for proper oral care.
- I authorize release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist and/or physician.
- I authorize DHC and/or its agents to transmit patient billing and/or insurance information to my insurance carrier electronic communication address in lieu of U.S. Postal Service.
- I authorize DHC to communicate through the use of electronic mail and text messages for:
    - appointment reminders; bills and other financial information; unfinished treatment plans which may contain information related to health issues identified by DHC during previous appointments; and any other information related to my oral care treatment that DHC believes necessary.
    - I have the email address and cellphone number listed in this form for that purpose.
    - I understand that it is my responsibility to notify DHC when my email address changes as soon as is practical.
    - I understand that email and text messaging is being used for my convenience and privacy and improved efficiency in communicating with DHC.
    - I will not hold DHC responsible for disclosures that occur due to other individuals reading e-mails and/or text messages sent to the address provided below.
- I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services.
- I understand that I am financially responsible for payments in full for my dental account at time of service.
- By signing this form. I agree to be responsible for payment of services not paid, in whole or in part, by my dental plan payer.
- DHC is authorized to provide any insurance company, administrator, and consulting health care professional, information concerning health care advice, treatment or supplies provided. This information will be used for die purpose of evaluating and administrating claims for benefits. This authorization is valid for the tenure of coverage by the policy or contract in force on this date only. I know I have the right to receive a copy of this authorization upon request and agree that the photocopy of this authorization is as valid as the original.
- I hereby authorize payment directly to DHC of the oral care benefits otherwise payable to me.

Financial Obligations

Specific Charges That Apply To You, the Patient

Cleanings (not all cleanings are free)

- Cleanings that are covered 100% under your oral care plan are routine/simple cleanings only. "Routine" means above the gum line. Patients who have tartar, plaque, or buildup under the gum line require a different, more involved cleaning procedure. There is a completely different billing code and charge for these types of cleanings, and your oral care plan may, or may not, cover it. Most patients who have not been examined by DHC for more than six months require more than a routine cleaning. It is not appropriate for us to perform a routine cleaning and leave the debris under the gums. Professional treatment standards require your DHC dental hygienist or dentist to clean properly under the gum line in order to restore your oral health. We encourage you to ask your DHC hygienist or dentist after your complete examination which type of dental cleaning will be necessary to address your oral care.

We Are a Mercury-Free Office

- We believe that mercury is a toxic substance that should not be put in your mouth. Therefore, **we do not provide amalgam fillings** that contain mercury. DHC fillings are made of composite, mercury-free materials. Some insurance companies **will only partially cover composite fillings** in posterior teeth. We strongly believe that keeping your body free from toxic materials like mercury is worth the small difference in your co-pay for composite fillings.

CONTINUED....

Patient Initials _____

Anxiety Management

- We understand that visiting a dental office can cause anxiety, so we offer **CBD at $5 per dropper** for patients that choose to use it during their visit. Unfortunately, this is not yet covered by insurance in the State of Colorado.

Probiotic Treatment

- We offer an **oral probiotic regimen** that is used to facilitate optimal oral health and wellness. Unfortunately, this is not yet covered by insurance in the State of Colorado.

Financial Policy

We want to avoid any misunderstanding about our financial policy as it relates to your responsibility for your account. Please read the following information and be sure to contact DHC staff with any questions you may have.

- If you have dental and/or medical insurance, we are glad to help you obtain the appropriate benefit from your insurance carrier and bill them as a courtesy to you. However, you are responsible for the payment of your account. We accept cash, check, money order, and credit cards (**Visa and MasterCard only**).
- Portions of your bill might not be paid by the insurance carrier and must be paid by you. Any insurance deductible or co-payment required by your insurance carrier is **due at the time services are rendered**.
- If you do not have insurance coverage or if you have a managed care or a discount plan, **payment is due at the time services** are rendered; unless other arrangements have been made prior to your appointment.
- If your treatment plan requires a high out-of-pocket expense to you, our office manager can **assist you in arranging financing** or a payment schedule.
- If you fail to keep your scheduled appointment or cancel your appointment without 24 hours' notice, your account will be charged a **$40.00 broken-appointment charge**.
- Insurance claims are processed to the insurance company one time for your convenience. If the claim requires additional processing there is a **$25.00 claim processing fee** each additional time the claim is processed.
- Problems with incomplete, incorrect, and/or wrong insurance information that delay the billing process and your treatment will incur a **$50.00 fee for the correction** and reprocessing of your account.

Additional Terms

- Balances unpaid after 30 days from the date of billing are subject to a compound interest rate of **1.5%** per month (**18%** per annum).
- Accounts referred to collections will have collection costs added in the amount of **30%** of the outstanding balance, together with court costs and reasonable attorney's fees.

HIPAA Consent

- I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- I understand that by signing this consent I authorize you to disclose and use protected health information to carry out:
    - treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
    - obtaining payment from third payers (e.g. my insurance company); and
    - The day-to-day healthcare operations of your practice.
- I have also been informed of, and given the right to review and secure a copy of your 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 you reserve the right to change the terms of this notice from time to time and that I may contact DHC at any time to obtain the most current copy of this 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 healthcare operations, but that DHC is not required to agree to these restrictions. However, if DHC does not 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 revoked this consent, is not in effect.

CONTINUED....

Patient Initials _____

4. ACKNOWLEDGEMENT

Patient or Responsible Party

- I acknowledge that I have read the above information (Sections 3 and 4) and have had the opportunity to ask questions about its content. I accept full legal and financial obligation for the services that I agree to receive as recommended by the oral care professionals at DHC.

Print Patient Name _____

Patient/Guardian Signature X _____ **Today's Date** ___/___/___

Relationship to Patient _____

THANK YOU FROM YOUR DHC TEAM!

Here's to continued oral health and wellness!

DHC
Dental Health Colorado

FOR OFFICE USE ONLY

DHC Intake Staff Signature X _____ **Today's Date** ___/___/___