FEDERAL HEIGHTS
FAMILY DENTISTRY

Please fill out this form completely. It is important to your dental care. Our goal is to help you reach and maintain good oral health.

About you:

Date:_____

Name:_____ Preferred name: _____ Male ___ Female___
Last First Middle initial

___Married ___Single ___Partnered ___Divorced ___ Widowed

Birthdate:_____ Age:_____ SSN#: _____

Home Address: _____
Street City State Zip

Home #: _____ Cell #: _____ Work #: _____

E mail:_____

Preferred contact method / confirm appointments: text call email

Employer: _____ Employer address: _____
City State Zip

Occupation: _____ How Long there? _____

Whom may we thank for referring you to our office? _____

Spouse Information:

Name: _____ Birthdate: _____ SSN#: _____

Employer: _____ Work:_____ Cell #:_____

In the event of an emergency, whom should we contact?

Name: _____ Relation: _____ Work #: _____

Home #: _____ Cell #: _____ Address: _____

Person responsible for account if other than yourself:

_____
Name: Relation Phone #

Federal Heights Family Dentistry

Primary Dental Insurance Information:

Primary Policy Holder Name: _____

Policy Holder SS#: _____ Subscriber ID:_____

Group number: _____

Insured's Employer: _____ Insurance Company: _____

Insurance CO Address: _____

Secondary Dental Insurance information:

Secondary Policy Holder Name: _____

Policy Holder SS#: _____ Subscriber ID:_____

Group number: _____

Insured's Employer: _____ Insurance Company: _____

Insurance CO Address: _____

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Medical History

Name: _____ Date:_____

Family Physician's Name: _____ Physician phone #:_____

Date of last visit: _____ Current physical health is: __ Good __ Fair __ Poor

Are you under the care of a physician? __ Yes __ No

If yes, please explain: _____

Do you smoke or use tobacco of any form? __ Yes __ No

Are you allergic or had any adverse reactions to any of the following: (Circle)

Aspirin Codeine Dental Anesthetics Latex Sedatives Penicillin Other_____

Please list additional drugs/ materials that caused allergic reactions:_____

Are you pregnant or nursing? ___ Yes ___No

Are you taking any of the following? (Circle)

Blood pressure medication Antibiotics Steroids/Cortisone Heart medications Aspirin
Thyroid medication Insulin / Diabetes drugs Blood thinners Pain pills/ narcotics

Please list all your current medications: _____

_____

Are you currently or ever taken any Bisphosphonates (for bone loss/ osteoporosis)? __ Y __ N

Have you had any of the following diseases or medical problems: (please circle)

Abnormal Bleeding	Congenital heart defect	Heart Murmur	Mitral Valve Prolapse
Arthritis	Diabetes	Heart Surgery	Osteoporosis
Artificial Valves	Difficulty Breathing	Hemophilia	Pacemaker
Alcohol Abuse	Drug Abuse	Hepatitis	Persistent Cough
Artificial bones/joints	Emphysema	Herpes	Psychiatric Care
Anemia	Epilepsy	High Blood Pressure	Radiation Therapy
Asthma	Fainting Spells	HIV / AIDS	Stroke
Blood Transfusions	Fever Blisters	Hospitalization	Thyroid Problems
Cancer	Glaucoma	Kidney Problems	Tonsillitis
Chemotherapy	Hay Fever	Liver Disease	Tuberculosis
Chicken Pox	Headaches	Low Blood Pressure	Ulcers
Colitis	Heart Attack	Lupus	Venereal Disease

Patient signature (parent/guardian): _____ Date: _____

Provider signature: _____ Date: _____

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Dental History

What is the reason for your visit today? _____

Name / Location of your last dentist: _____

Date of last dentist visit: _____ Date of last full mouth x rays: _____

Do you wear any removable denture? __ Y __N

Are you happy with your denture? __Y __N Why? _____

Would you like to know more about permanent replacements? __ Y __N

Are you apprehensive about dental treatment? __Y __N

Have you had any periodontal (gum) treatment? __Y __N What kind? _____

Do your gums bleed or feel tender or irritated? __Y __N

Are your teeth sensitive to hot, cold, sweets, or pressure? __Y __N

Are you happy with the appearance of your teeth? __Y __N Why not? _____

Do you clench or grind your teeth? __Y __N

Do you have headaches, earaches, or neck pain? __Y __N

Do you have discolored teeth that bother you? __Y __N

Would you like your smile to look better or different? __Y __N

Federal Heights Family Dentistry

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care. Financial responsibility on the part of each patient must be estimated before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for in cash at time the services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and he/she is personally responsible for payment of all dental services.

This office will submit the patient's insurance forms or assist in making collections from insurance companies and will credit any such collection to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate provided for dental care can only be extended for a period of six months from the date the service was rendered.

In consideration for the professional services rendered to me, or at my request, I agree to pay the reasonable value of service to said Doctor, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. There will be a $25.00 fee assessed for a Nonsufficient funds check.

I agree that the reasonable value of services shall be billed unless objected to, by me in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all collection and attorney fees if suit were instituted.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature:_____ Date:_____

Print name: _____

Customer hereby acknowledges and agrees that any account that becomes delinquent will be subject to collections service. Customer agrees to pay all court costs and reasonable attorney fees for collection of all past due amounts owed.

Federal Heights Family Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT

Name:
Address:
Telephone:

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether or not to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any or your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting our office.

RIGHT TO REVOKE: You will have the right to revoke this consent at any time by giving us a written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke consent.

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: _____ Date:_____

Printed name:_____

Federal Heights Family Dentistry

Failed Appointment and Cancellation Policy

Please understand we reserved the appointment time specifically for only you. It is important that you come to your scheduled appointment. However, we understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. When you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you may be charged a no show/late cancellation fee; this will not be covered by your insurance company.

Our policy is as follows:

We require that you give our office at least 24 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that time slot.

If you miss an appointment or cancel with less than 24 hours notice, this is considered a failed appointment. A $50 per hour reserved fee will be charged to you. Example, an appointment reserved for a crown is usually 2.5 hrs, therefore the cancellation fee is $125. This cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without the payment of this fee. We reserve the right to require a deposit prior to reserving a future appointment. Third late cancel or failed appointment may result in dismissal from our practice.

Additionally, if a patient is more than 15 minutes late without prior notice for a scheduled appointment, we consider this to be a failed appointment and the $50/hour cancellation fee will be charged.

If you have questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

I have read and understand the appointment cancellation policy of the practice and I agreed to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

I, _____ (print name), I have received a copy of Federal Heights Family Dentistry's appointment cancellation policy.

Signature:_____ Date:_____

Federal Heights Family Dentistry

Authorization to release and discuss Dental information

The HIPAA Privacy Law requires that we are only authorized to communicate with the patients themselves, guardians, insurance providers, and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all my family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking the “do not release information” box below.

Authorization to speak with family / friend (including spouse)

I give the family named person(s) authorization to take messages or speak with the office a Federal Heights Family Dentistry on my behalf regarding (please circle all items authorized).

Name of authorized person(s): _____ Relationship: _____
Phone number_____ Appointments Financial Dental treatment Insurance
Other (explain)_____

Name of authorized person(s): _____ Relationship: _____
Phone number_____ Appointments Financial Dental treatment Insurance
Other (explain)_____

Name of authorized person(s): _____ Relationship:_____
Phone number_____ Appointments Financial Dental treatment Insurance
Other (explain)_____

____ DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any Healthcare information.

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the evolved parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient name:_____ Date of birth:_____

_____ _____
Signature of Patient(s) or Authorized Representative Date

Federal Heights Family Dentistry

New patient process practice policy on dental insurance

About Dental Insurance:

Rapid, confusing changes in the insurance industry are causing all of us in American society to reflect on and decide how we both give and receive Healthcare. In the past few years, I have deeply contemplated the meaning of these changes relative to my mission to render the best industry I am capable of in an environment which truly cares about each and every one of you. With this in mind, let me share a few Thoughts with you.

Insurance companies are in business to make money. They are not concerned with caring for your teeth or health; in fact, it is in the insurance company's best interest if you do not see any health care. That way, they earn money on your premium dollar without having to do anything for your health. Seminars and newsletters do dentists are filled with stories of insurance companies tactics and delaying payments to dentists and denying needed treatment to patients.

In recent years, the insurance industry has moved rapidly in ways which interfere with or destroy that doctor-patient relationship, which I hope as one of the few remaining secret things left in Modern Life. In fact, I believe that my devotion to each and every one of you is one of the key factors which makes our practice special and is also why you have chosen us and have it remained with us.

When dental insurance came into the consumer Market in the 1970s, an individual's maximum annual benefit was $1,000. I find it amazing that, although premiums for these policies have risen dramatically, the maximum benefits have remained the same. In other words, what was a very generous benefit 30 years ago is a very paltry sum now. Think of what $1,000 bought in 1970 compared to today!!

We want you to receive the maximum insurance benefit to which you are entitled and will work very hard to assure this; however, we realize that an insurance policy is a contract between you (or your employer) and the insurance company, subject to the rules and regulations which we cannot control. We will also never make any health care decisions based on the edicts of any third-party which puts profits ahead of human well-being.

Like medical Insurance, dental coverage was never intended to be all encompassing. With this in mind, please understand that even the best policies today cannot be viewed as anything other than a payment assistant program with some very severe limits. Please note that my staff and I are devoted to your well-being and will help you make decisions which will preserve the health, comfort, function and aesthetics of your mouth. Be cautious of what any for-profit third party has to say. We will do all we can to assist you in paying for what we consider to be excellent care; however, we will not compromise on the nature of the quality of our treatment of any human being.

Please feel free to discuss this issue openly with my staff or myself.

Federal Heights Family Dentistry

Our philosophy of practice:

For patients to choose a dental office appropriate to their needs, there must be a match between a service the patients needs with services provided by the office. If the value you possess for your teeth and health coincides with our beliefs in fine dentistry and prevention, a mutually rewarding relationship should evolve for both parties. Essay for my welcoming you and sharing our beliefs about how we serve patients, the following is provided.

Briefly stated, our philosophy of his practice is this…"Our goal is to provide you with quality Dentistry to help you keep all your teeth for the rest of your life in maximum health, comfort, function, and appearance at a minimum of stress, discomfort, and expense."

A dental office is a small health-oriented team of professionals dedicated to serving patients. Each office maintains certain standards of skill and concern and we want an aura about us that unquestionably makes a statement of our quality of care. To make this evident, we have committed to a particular kind of practice. You want to attract and keep people who share our values and beliefs in excellence or can grow to this level of appreciation through education and motivation. We seek a patient population dominated by people with high expectations of good health and happiness.

Examination process:

Excellence in dentistry begins with a careful diagnosis and treatment plan to move us toward the goals we will establish together. We will perform an extensive and comprehensive examination of the teeth, gums, bite, joints, and soft tissues. We will utilize all appropriate x-rays and intraoral photographs and study models of your teeth. We believe this in-depth examination to be the Cornerstone of quality Dentistry.

Maintenance of Traditional Values…

With a government becoming more involved in healthcare, insurance carriers trying to dictate treatment and fees, and some dental offices competing through advertising, extended hours and pricing, the very Foundation of Dentistry is being tested. We believe there has never been a time when you practice dedicated to prevention, to service, into excellence can be more highly rewarding to both our patients and to us, and providing quality, long-term healthcare.

We hope you agree and will join our family!