FAMILY DENTISTRY
COLORADO SPRINGS

Adult Dental Registration

Patient Information

Patient Name _____ DOB ___/___/_____ □ Male □ Female
Address _____ City _____ State ____ Zip _____
Phone Number: Cell _____ Home _____ Work _____
Social Security # _____-_____-_____ □ Married □ Single □ Divorced □ Widowed □ Other
Email Address _____
Employer _____ Address _____
May we use your email and/or cell phone number to send appointment reminders, confirm your appointment or other information regarding your dental care? □ Yes □ No

Primary Dental Insurance □ Patient is policy holder □ N/A
Insurance Company _____ Group # _____ Contact # _____
Subscriber Name _____ Relationship to Patient _____
DOB ___/___/_____ SS/ID#_____
Address (if different from patient) _____ City _____ State ___ Zip _____

Secondary Dental Insurance □ N/A
Insurance Company _____ Group # _____ Contact # _____
Subscriber Name _____ Relationship to Patient _____
DOB ___/___/_____ SS/ID#_____
Address _____ City _____ State ____ Zip _____

How did you hear about Family Dentistry of Colorado Springs?

□ Referral (their name) _____ □ Postcard □ Building Sign □ Insurance Company
□ Website □ Social Media □ Yelp Online Review □ Google Online Review □ Welcome letter/brochure
□ I dreamed I should come here □ Other _____

Cosmetic and Special Services

Are you interested in receiving information on any of the following services?
□ Invisalign Teeth Straightening □ Lumineers/Veneers □ Dental Implants □ Other _____

I am changing dentist because:

□ Recently moved into this area from _____ □ Dr/Staff personality □ Communication problems
□ Inadequate care □ Fee concerns □ Insurance □ Need a 2nd opinion or better option on dental care
□ To find a dentist team who understands my needs □ Other _____

I have avoided dental care in the past because:

□ Fear of _____ □ Time commitment □ No perceived need □ Financial commitment □ Trust

Personal Interests Information:

Where are you from originally? _____ Your occupation and job? _____
Spouse's name &occupation? _____ Children's name, ages? _____
Schools attended? _____ What's more fun than dental visits? _____

Assignment and Release (please sign this section if covered by a dental insurance policy)

I certify that I, and/or my dependent(s), have insurance coverage with _____
(Name of Insurance Company)
and assign directly to Family Dentistry of Colorado Springs and its associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company and furthermore that all dental estimates provided are not a guarantee of coverage or payment and the insurance coverage policy is between myself and the dental insurance company and that Family Dentistry of Colorado Springs is the dental service provider in the relationship. I authorize the use of my signature on all insurance submissions. Family Dentistry of Colorado Springs and its associates may use my health care information and may disclose such information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services

Signature of Patient or Authorized Signer _____ Date ____/____/_____

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Dental and Medical History Information

Dental History

Patient Name: _____ Reason for today's visit: _____

Former Dentist: _____ City/Phone: _____/(_____)_____-_____

Date of last dental exam: _____ Date of last dental x-rays: _____ How often do you brush? _____ Floss?_____

Were there treatment recommendations by your previous dentist that were not completed? □ Yes □ No

Please check all that apply:

□ Bad Breath
□ Bleeding gums
□ Blisters on lips or mouth
□ Burning sensation on tongue
□ Chewing on one side of mouth
□ Cigarette/pipe/cigar smoking
□ Clicking or popping jaw
□ Dry mouth
□ Fingernail biting
□ Food collection between teeth
□ Foreign objects
□ Grinding teeth
□ Gums swollen or tender
□ Jaw pain
□ Jaw tiredness
□ Lip or cheek biting
□ Loose teeth/broken fillings
□ Mouth breathing
□ Mouth pain, brushing
□ Orthodontic treatment
□ Pain around ear
□ Periodontal treatment
□ Sensitivity to cold
□ Sensitivity to heat
□ Sensitivity to sweets
□ Sensitivity when biting
□ Sores/growths in mouth

Medical History

Physician's Name: _____ City/Phone: _____/(_____)_____-_____ Date of last visit: _____

Please check all that apply:

□ AIDS/HIV
□ Anemia
□ Arthritis, Rheumatism
□ Artificial Joints
□ Asthma, Use Inhaler: □ Yes □ No
□ Blood Disease
□ Cancer, type _____
□ Chemical Dependency
□ Chemotherapy, when_____
□ Circulatory Problems
□ Congenital Heart Lesions
□ Cortisone Treatments
□ Cough, persistent/bloody
□ Diabetes
□ Dizziness
□ Emphysema
□ Epilepsy
□ Excessive Bleeding
□ Fainting
□ Glaucoma
□ Headaches
□ Heart Murmur
□ Heart Problems
□ Hepatitis, type___
□ Herpes
□ High Blood Pressure
□ Jaundice
□ Jaw Pain
□ Kidney Disease
□ Liver Disease
□ Low Blood Pressure
□ Nervous Problems
□ Pacemaker
□ Psychiatric Care
□ Weight Loss/Gain
□ Radiation Therapy, when_____
□ Respiratory Disease
□ Rheumatic Fever
□ Scarlet Fever
□ Shortness of Breath
□ Sinus Trouble
□ Skin Rash
□ Special Diet
□ Stroke
□ Swollen Feet/Ankles
□ Swollen Neck Glands
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis
□ Tumor on Head/Neck
□ Ulcer
□ Venereal Disease

Have you ever taken a medication that contains bisphosphonates? This includes brands such as Actonel, Aredia, Boniva, Didronel, Fosamax, Zometa. □ Yes □ No

Do you wear contact lenses? □ Yes □ No

Woman only: Are you pregnant? □ Yes □ No Are you taking birth control pills? □ Yes □ No Are you nursing? □ Yes □ No

Medications (List any medications you are currently taking):

_____
_____
_____

Allergies (Please check all that apply):

□ Aspirin □ Codeine □ Erythromycin □ Latex □ Local Anesthetic □ Metals □ Penicillin □ Sulfa □ Tetracycline □ Other_____

I certify to the accuracy of the above statements regarding my medical and dental history

_____ _____ _____
Signature of patient, parent guardian or representative | Print name of patient, parent guardian or representative | Date

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General Information and Consent for Treatment

1. **Patient Identification:** Family Dentistry of Colorado Springs takes steps to help ensure the security of our patient's personal information. This process is done by verifying the identity of all patients during their visits to Family Dentistry of Colorado Springs. All patients (excluding individuals under the age of 16) are required to present a valid photo identification such as a Colorado driver's license, Colorado identification card, passport or other government-issued photo identification at their initial dental appointment. In addition, all patients at the initial appointment will be photographed for their patient chart.
2. **Notice of Privacy Practices:** Family Dentistry of Colorado Springs may release information to other entities or healthcare providers, for treatment, for payment of services and for health care operations as described in the "Notice of Privacy Practice."
3. **Right to Discontinue Treatment:** I understand that Family Dentistry of Colorado Springs has the right to discontinue my care for any appropriate reason, such as excessive missed appointment or lack of compliance. In such cases, the patient or patient's representative agrees to accept full responsibility for pursuing alternate professional dental care. All records pertaining to treatment and diagnosis are the property of Family Dentistry of Colorado Springs. Records and x-rays may be duplicated upon written request with a reasonable charge.
4. **Risks of Dental Treatment:** The dentists and support staff of Family Dentistry of Colorado Springs are available to answer any questions pertaining to risks of dental procedures. All dental procedures have certain risks; including possible side effects from medicines used. The risks include, but are not limited to: allergic reactions, cuts/abrasions, tenderness/bruising, and tooth sensitivity.
5. **Patient Communications:** I authorize Family Dentistry of Colorado Springs to communicate through the use of electronic mail; appointment reminders, billing and other financial information, unfinished treatment plans which may contain information related to health issued identified by my dentist during previous appointments. I am willing to provide my email address for the purposes identified above. I understand it is my responsibility to notify my dentist when my email address changes as soon as is practical. I understand that email is being used for my convenience, privacy, and improved efficiency in communicating with my dentist. I will not hold the dentist responsible for disclosures that may occur due to other individuals reading emails sent to the email address provided to the dental office.
6. **Fees and Payment of Services:** Services are provided on a pay as you go basis unless alternative financial arrangements have been made prior to rendering care. Patients are expected to pay for services at the time services are rendered. Cash, personal check, VISA, MasterCard, Discover, and American Express are accepted. Insurance payments are accepted; those charges not covered by insurance remain the responsibility of the patient and are due at the time of the service.
7. **Insurance Claim Submission:** I authorize Family Dentistry of Colorado Springs to transmit patient billing and/or insurance information to my insurance carrier via electronic or standard U.S. Postal Service communications.
8. **Patient Acceptance:** Family Dentistry of Colorado Springs accepts patients for treatment regardless of race, color, religion, gender, age, national origin, or individual disability.

General Dentistry Informed Consent for Treatment

This General Dentistry Informed Consent for Treatment includes but is not limited to:

- Extracting teeth
- Dental implants
- Dentures or partial dentures
- Local anesthesia and medicines
- Restoring teeth with fillings or crowns, bridges, veneers, inlays, or onlays
- Root canals

I understand that specific informed consents may be made available for any or all of the above procedures. I understand that because of the very nature of any proposed treatment and the uniqueness of myself as an individual; no one can predict the certainty of any outcome or success of any dental treatment. I understand that dental treatment contains no guarantees, warranty, or assurance of success. Each individual case is unpredictable making it impossible to surmise results. I further understand that the results may NOT be to my complete and full satisfaction after treatment is complete and my condition may be the same, better or worse.

I understand that if a prescription is written for a controlled substance, state law requires that certain prescription information, including my name, be entered into a secure database (Colorado's prescription drug monitoring program) when I fill this prescription at my pharmacy. Authorized prescribers of controlled substances and law enforcement, in limited circumstances, may access the database for allowed uses.

I have read and understand all of the above patient information contained on this document and agree to abide by all of the procedures and conditions specified. I hereby give permission for diagnosis and /or treatment at Family Dentistry of Colorado Springs for myself or for the minor child named in this document.

Patient Name: _____ Date: _____

Patient or Guardian Signature: _____

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Financial Policy

In order to enhance communication and provide transparency regarding our financial policy, please read through the following information. After reading, please provide your signature at the bottom of this document indicating that you fully understand this policy. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please speak with one of our front office representatives. Thank you for taking the time to review this information!

- **Dental Insurance:** Family Dentistry of Colorado Springs will bill both primary and secondary (if applicable) insurance company as a ***courtesy*** for our patients. It must be understood that each patient is ultimately responsible for the cost of services rendered. Please understand that Family Dentistry of Colorado Springs is a third party provider and the relationship pertaining to your insurance is between you and your insurance carrier. We will do our best to provide you with accurate insurance coverage and estimated patient portion; however your policy is subject to change at any time and there is never a guarantee of coverage until the claim is paid in accordance with your dental policy. If the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment on the account balance would be expected within 30 days of closure of the insurance claim.
- **Patient Payment:** The patient portion is due at the time services are rendered unless previous arrangements have been made with the office manager. We accept cash, checks, money orders, and all major credit cards.
- **Financing**: We have financing through Care Credit. If you have an interest in this option, please consult with the Office Manager prior to the date of your treatment.
- **"No Show"/Missed Appointments:** We request notice to cancel or reschedule an appointment at least 24 hours in advance of your appointment time. If appropriate notice is not given, a charge of $25 may be assessed to the patient's account. For appointments scheduled longer than 1 hour, an additional charge of $25 will be charged for each hour of the appointment length (i.e. $50 for a 2 hour appointment, $75 for a 3 hour appointment).
- **Refunds for Unfinished Treatment:** If a patient decides to discontinue treatment after it has been started, no refund will be provided! Individual circumstances may be discussed with the Office Manager and/or treating dentist.
- **Credit on an Account:** If an account credit exists on the patients account, we are happy to refund the patient or the credit can remain on the account to be applied to future treatment. If the credit exists because of an overpayment by the insurance company we will provide a payment directly to your insurance company for that erroneous overpayment.
- **Balances:** Balances unpaid after 30 days from the billing date are subject to a finance charge at a rate of 1% per month (12% per annum).
- **Collections:** On occasion, after repeated attempts to collect a balance due, we may need to turn the account over to a collection agency. Therefore we encourage the patient to contact us if you are unable to make a payment on an overdue account balance rather than ignoring the any correspondence and our attempts to collect on the balance. Should an account be turned over the collection agency, it is agreed that the financially responsible party listed below shall pay all finance charges, collection cost, attorney fees, and any other costs that may be incurred to enforce collection of any amount outstanding.
- **Returned Checks:** A $35 fee will be applied for checks returned for insufficient funds or closed accounts, and may also prevent us from accepting checks as a form of payment for your dental treatment in the future.

I acknowledge that I have read the above information and have been provided with an opportunity to ask questions about its content. I accept full financial obligation for the services I receive by the dental professionals at Family Dentistry of Colorado Springs

Name of Patient or Responsible Party: _____ Date: ___/_____/_____

Signature of Financially Responsible Party: _____

Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgment****

If the patient is under 18 years of age, a parent or legal guardian must sign.

I,_____, have been informed of this office's Notice of Privacy Practices.
{Please Print Patients Name}

_____
{Signature of Patient or Parent/Legal Guardian}

_____
{Date}

For Patients who need pre-medication only:
I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox or with whoever answers the telephone. I also authorize this office to remind me of my pre-medication on any postcard reminders that the office will mail to me.

Colorado Prescription Monitoring Program Notification: By acknowledging this HIPAA compliance form, I understand that prescriptions provided to me by any dentist of Family Dentistry of Colorado Springs will be registered with the Colorado Prescription Monitoring Program per state mandated regulations for all pharmacists, doctors, and healthcare providers.

_____
{Signature of Patient or Parent/Legal Guardian}

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 acknowledgment
- ☐ Patient reviewed Privacy Practices but elected not to take a copy home
- ☐ Other (Please Specify)

Employee signature:_____Date: _____