

Patient Information

Patient's Name: _____ Date: _____
 Social Security Number: _____ DOB: _____ Marital Status: _____
 Mailing Address: _____
 City: _____ State: _____ Zip Code: _____
 Home Phone: _____ Cell Phone: _____ Text Message? **Yes No**
 Email: _____ Employed By: _____
 Spouse's Name: _____ Spouse's Social Security: _____
 Spouse's Birthdate: _____ Spouse Employed By: _____
 How did you hear about us? _____
 Who will pay this account? _____ Dental Insurance Company _____
 Emergency Contact: _____ Emergency Contact Phone Number: _____

Health History

<p>My current medical health is: Please check one ☐ Excellent ☐ Good ☐ Fair ☐ Poor</p> <p>❖ List all medications you take (Rx and OTC):</p> <p>❖ List any known drug allergies:</p> <p>❖ Have you had a serious illness, operation or been hospitalized in the past 5 years? If so, describe:</p> <p>❖ Please list any conditions not listed to the right, or any additional information you believe will aid us in helping you</p> <p>❖ Are you pregnant or nursing? ☐ Yes ☐ No</p> <p>❖ Date of last dental visit? _____</p> <p>❖ Date of last dental cleaning? _____</p>	<p>Please check the box if you currently have or have had any of the following diseases or problems:</p> <table style="width: 100%;"> <tr> <td>☐ Artificial Heart Valve</td> <td>☐ Tobacco Use</td> </tr> <tr> <td>☐ Pacemaker</td> <td>☐ Alcoholism</td> </tr> <tr> <td>☐ Previous Endocarditis</td> <td>☐ Seizures</td> </tr> <tr> <td>☐ Chest Pain upon exertion</td> <td>☐ Drug Dependency</td> </tr> <tr> <td>☐ Asthma</td> <td>☐ AFib</td> </tr> <tr> <td>☐ Chronic Cough</td> <td>☐ Heart Disease/Failure</td> </tr> <tr> <td>☐ Breathing Disorders</td> <td>☐ Stroke</td> </tr> <tr> <td>☐ Low Blood Pressure</td> <td>☐ Weight Gain</td> </tr> <tr> <td>☐ Bleeding Disorders</td> <td>☐ CPAP use</td> </tr> <tr> <td>☐ Anemia</td> <td>☐ Difficulty Staying Asleep</td> </tr> <tr> <td>☐ Osteoporosis</td> <td>☐ Family History of Sleep Apnea</td> </tr> <tr> <td>☐ Arthritis/Rheumatism</td> <td>☐ Diabetes <u>Type 1</u> or <u>2</u></td> </tr> <tr> <td>☐ Immune Disorders</td> <td>☐ Acid Reflux</td> </tr> <tr> <td>☐ Hemophilia</td> <td>☐ Sleep Apnea</td> </tr> <tr> <td>☐ Kidney Problems</td> <td>☐ Thyroid Problems</td> </tr> <tr> <td>☐ Liver Disease</td> <td>☐ Head, neck, jaw pain</td> </tr> <tr> <td>☐ Alzheimer's/Dementia</td> <td>☐ Daytime tiredness</td> </tr> <tr> <td>☐ Total Joint replacement</td> <td>☐ Chronic Pain</td> </tr> <tr> <td>☐ Head & Neck Radiation</td> <td>☐ Taken a sleep test</td> </tr> <tr> <td>☐ Cancer/Tumor</td> <td>☐ High Blood Pressure</td> </tr> <tr> <td>☐ Organ Transplant</td> <td>☐ Snore</td> </tr> <tr> <td>☐ Epilepsy</td> <td>☐ Headaches</td> </tr> <tr> <td>☐ Fainting Spells</td> <td>☐ Mornings feel great: <u>Y</u> or <u>N</u></td> </tr> <tr> <td>☐ Alzheimer's/Dementia</td> <td></td> </tr> <tr> <td>☐ Mental Health Disorder</td> <td>Height:</td> </tr> <tr> <td>☐ Eating Disorder</td> <td></td> </tr> <tr> <td>☐ Hepatitis (A,B,C)</td> <td>Weight:</td> </tr> <tr> <td>☐ Aids or HIV Infection</td> <td></td> </tr> </table>	☐ Artificial Heart Valve	☐ Tobacco Use	☐ Pacemaker	☐ Alcoholism	☐ Previous Endocarditis	☐ Seizures	☐ Chest Pain upon exertion	☐ Drug Dependency	☐ Asthma	☐ AFib	☐ Chronic Cough	☐ Heart Disease/Failure	☐ Breathing Disorders	☐ Stroke	☐ Low Blood Pressure	☐ Weight Gain	☐ Bleeding Disorders	☐ CPAP use	☐ Anemia	☐ Difficulty Staying Asleep	☐ Osteoporosis	☐ Family History of Sleep Apnea	☐ Arthritis/Rheumatism	☐ Diabetes <u>Type 1</u> or <u>2</u>	☐ Immune Disorders	☐ Acid Reflux	☐ Hemophilia	☐ Sleep Apnea	☐ Kidney Problems	☐ Thyroid Problems	☐ Liver Disease	☐ Head, neck, jaw pain	☐ Alzheimer's/Dementia	☐ Daytime tiredness	☐ Total Joint replacement	☐ Chronic Pain	☐ Head & Neck Radiation	☐ Taken a sleep test	☐ Cancer/Tumor	☐ High Blood Pressure	☐ Organ Transplant	☐ Snore	☐ Epilepsy	☐ Headaches	☐ Fainting Spells	☐ Mornings feel great: <u>Y</u> or <u>N</u>	☐ Alzheimer's/Dementia		☐ Mental Health Disorder	Height:	☐ Eating Disorder		☐ Hepatitis (A,B,C)	Weight:	☐ Aids or HIV Infection	
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I certify that the information provided above is accurate and that I will inform the dental team of any changes to my health or medications. I authorize Greeley Dental Care to perform procedures. I also authorize my insurance benefits to be paid directly to Greeley Dental Care. I understand that I am financially responsible for ALL services, to include interest and rebilling charges. I also authorize Greeley Dental Care to release any information required. I have read our office's privacy policy. By providing us with your phone number(s) you give authorization for us to contact you through the provided number(s).

Signature

Date

GREELEY DENTAL CARE
1813 61st Avenue, Suite 210
Greeley, CO 80634
970-352-4242

Personal HIPPA- Consent to Release Information

This notice allows Greeley Dental Care to release dental and/or financial information to a named relative or contact that may call requesting information, on your behalf.

I, _____ (your name) hereby authorize Greeley Dental Care to disclose/release information to the following individuals on my behalf:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

The above mentioned individuals may have access to which sets of records?:

(PLEASE CIRCLE APPLICABLE) All records Dental only Financial only

Patient signature: _____ Date: _____

Cancellation policy:

Your appointments are important to us.

If you have not confirmed your appointment via text message, someone from our practice will call you as early as 4 days before your scheduled appointment. If your appointment is still unconfirmed 48 hours before your appointment, your reserved time cannot be guaranteed.

If you cannot avoid rescheduling an appointment, please advise us at least **48 hours** in advance so that we may offer that time to another patient in need.

A \$50 fee will be assessed if 48 hours notice is not given.

By signing below, you are agreeing to both of these conditions.

Patient signature: _____ Date: _____

GREELEY DENTAL CARE
1813 61 Avenue, Suite 210
Greeley, CO 80634

GENERAL CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (paresthesia).** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding.**
5. **Swallowing or inhaling a small object.**

While we follow procedural guidelines which most often lead to clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

Please advise us at least 48 hours before your appointment if you cannot avoid rescheduling.

A \$50 fee will be assessed if 48 hours' notice is not given.

I have read and understand the statement on this page. I have also been presented/read our notice of privacy practices form.

Patient Signature

Date

Parent Signature (if minor patient)

Date

INFORMATION FOR OUR PATIENTS WITH DENTAL INSURANCE

Dental insurance is playing a larger role in helping people obtain dental treatment. Since we feel strongly that our patients deserve the best dental care we can provide, and in an effort to maintain a high quality of care, we would like to share some facts about dental insurance with you.

We consider our relationship with you to be of primary importance and will always make our recommendations to you based on what we believe is the very best treatment for you regardless of your insurance coverage. As the patient, it is your responsibility to deal with your insurance company and your employer. We will assist in any way possible to maximize your dental insurance benefits, but to re-emphasize; we have no relationship or responsibility to your insurance company.

FACT #1: Dental Insurance is not meant to be a "PAY-ALL"; it is only meant to be an aid.

FACT#2: Many plans tell their insured that they will be covered "up to 80%" or "up to 100%". In spite of what you're told, we've found many plans cover 40% to 50% of an average fee. Some plans pay more...some pay less. The amount your plan pays is determined by the contribution you and your employer make to your dental plan. The smaller the contribution paid into the plan for "insurance", the less you'll receive. It is your responsibility to advise us of your insurance coverage and restrictions.

FACT #3: It has been the experience of many dentists that some insurance companies tell their customer that "fees are above the usual and customary fees" rather than saying to them the "our benefits are low". Remember you get back only what you and your employer put into your insurance coverage less the profits of the insurance company. It is a contract between your employer and the insurance company and we are not privy to that contract. In dealing with hundreds of dental insurance plans, most plans do cover our fees.

FACT #4: Each plan utilized in our office has different percentages, deductibles, maximums, procedures covered, and varying fees that the plan will allow. We will do our very best to make as close a calculation as possible of what your insurance plan will cover. However, as we cannot estimate precisely, there may be variances for which the patient is individually responsible.

FACT #5: Many routine dental services are NOT covered by insurance carriers. We make our recommendations based on your needs and **not on what your insurance may or may not cover.**

Please do not hesitate to ask us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our services and/or fees. We will fill out and file insurance forms at no charge. We will do all we can to assure you of your maximum benefits.

If you have any questions regarding your insurance, please contact your insurance carrier regarding the specifics and details of the plan they are operating on your behalf.

I authorize the release of all necessary information.

I authorize payment of benefits directly to the provider.

I have read this form and agree to be financially responsible for all fees regardless of insurance coverage.

EVEN IF YOU DO NOT HAVE INSURANCE, PLEASE SIGN IN CASE YOU GET DENTAL INSURANCE AT A LATER DATE.

Signature: _____

Date: _____

Office Signature: _____

Date: _____

Good Faith Statement

We believe that open communication and understanding are essential for successful care and to maintain a complimentary working relationship. Please take a few moments to clarify some of the frequent concerns we have experienced in our practice.

Please initial each line to show that you agree to that statement.

_____ **Appointments reserve your time as well as ours. If the rare occasion happens that you cannot avoid rescheduling an appointment, please advise us at least 48 hours before your appointment so that we may offer that time to another patient. A \$50 fee will be assessed if 48 hours' notice is not given.**

_____ **We are committed to your lifelong dental health.** Greeley Dental Care recommends treatment based on a comprehensive exam. It is our goal *and our responsibility* to offer you the very best in preventive, restorative and cosmetic dentistry.

_____ **Our Doctors places only composite (tooth-colored) fillings for restorations.** He strongly feels that is the best alternative for all patients, including children, and has not used amalgam (silver) materials for many years. * **Many insurance benefits are based on the cost of amalgam fillings.***

_____ **There is often confusion between a 'regular' cleaning and 'periodontal therapy.'** A person who has had consistent dental care and has minimal symptoms of gum disease will typically need a 'regular' cleaning twice a year. If a person has *not* had consistent care and has heavy build-up (tartar) or bleeding gums, one or several 'periodontal ' cleaning appointments may be needed. A 'regular' cleaning *cannot* be performed on a person whose dental health necessitates periodontal treatment.

*Most insurance companies consider periodontal procedures in the Restorative or Class II category of coverage rather than as Preventive Service.

_____ **Payment for services will be arranged prior to treatment.** We accept cash, personal checks, and most major credit cards as payment for services. Please feel comfortable asking your patient care coordinator about the numerous outside financing options made available for you *prior* to your treatment appointment. Accounts with a returned check will be charged a \$30.00 returned check fee.

_____ **Dental Insurance.** If you have dental insurance, we will estimate the amount due from insurance even though **all account balances are the responsibility of the patient.** It is the responsibility of the subscriber to pursue reimbursement from the insurance company for claims older than 90 days. Please remember that insurance estimates are based on verbal, computer responses, or faxed information provided by your insurance company and are not a guarantee of payment. The amount of insurance coverage is an estimate only and may not reflect what your insurance carrier will actually pay. The insurance company will make a final determination, once the claim has been processed.

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Not every service is a covered benefit with all insurance contracts. Some insurance companies are selective in what services are covered. Our concern is your well-being not what the insurance will cover.
3. Services cannot be provided on the assumption that charges will be paid by the insurance company: therefore, the patient is responsible for the bill, regardless of the insurance coverage. We do not let insurance dictate what is best for you.

*Researching, estimating, and submitting your insurance is a courtesy we provide at no cost. We expend extensive staff time in the effort to have the most accurate information possible; however, precisely because we are a third party, we cannot take responsibility for specific insurance policy limitations or exclusions, or for providing information due from the subscriber.

Please feel comfortable reviewing both your treatment plan and financial considerations prior to your appointments. We strive to help you feel confident in your relationship with us. Thank you again for taking the time to review this information.

-Greeley Dental Care

CUSTOMIZED TREATMENT & PRESENTATION QUESTIONNAIRE

Reason for visit today?

When it comes to dentistry, do you consider yourself to be a proactive or reactive person? (please check one)

_____ Proactive (one who likes to avoid complications, get rid of issues immediately)

_____ Reactive (one who would rather wait and deal with issues as they develop, even if that means costing more time, visits, money and/or pain to fix down the road)

Greeley Dental Care Small Balance Agreement

Sometimes insurance will pay less than we expect them to. In this instance, the remaining balance is the responsibility of the patient. This Small Balance Agreement is a courtesy service to our patients, and is optional.

I hereby authorize Greeley Dental Care to automatically withdrawal payments, that are under \$99 from the credit card account listed below in order to pay off balances on my account. I understand that the card listed below will only be used for automatic withdrawal under the circumstances listed. **I understand that I will receive a statement in the mail two weeks prior to the insurance underpayment transaction in case I need to change my card information or make other payment plans.**

Card information

Name on Credit Card: _____

Credit Card Number: _____

Credit Card CVV Number: _____

Credit Card expiration date: _____

Today's date: _____

Patient signature: _____