TIME DATE

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time Date

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	PreMed ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Yellow Jaundice ○ Yes ○ No			

Have you ever had any serious illness not listed	○ Yes ○ No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

Dentistry at Happy Canyon Office Policy

Payment will be expected at the time of service for all fees and co-pays.

Insurance contracts: If we have a "Participating Contract" with your insurance carrier, we will accept assignment on all Covered Services and bill your carrier for you. You are responsible for the co-pay, co-insurance, deductible and for all non-covered services.

Insurance plans represent a contract between yourself and the insurance company. These contracts are not between the doctor and the insurance company. We will do our best to help you obtain benefits, but we cannot be responsible if your carrier does not pay.

If your insurance is not found to be in force on the date dental services are provided, you will be responsible for the full balance based on usual and customary fees. A in office discount program is available for you to enroll in with immediate coverage.

Third Party financing may be available for qualifying applicants.

If at any time you have questions regarding any treatment, fees, or services, please discuss them with us promptly. We will make every effort to avoid a misunderstanding, to rectify an injustice, or to preserve a friendship.

Missed appointments: Our policy is to charge for missed appointments unless a cancellation is received at least **48 hours in advance**. The charge is **$50 per hour of scheduled time**. We send email reminders, text reminders, and a courtesy phone call to ensure you are aware of your scheduled appointment time.

Children in the office: Please make arrangements for non-scheduled children prior to your visit. All children age 17 and under must be accompanied by a parent or legal guardian during their appointment.

Senior discount: Senior Citizens age 65 and older will receive a 10% discount off usual and customary fees if non-insured.

X-rays and records: A $25 fee is charged to each patient requesting a copy of x-rays. Records will be released without x-rays at no charge. Please allow at least 5 business days for your x-rays and records to be duplicated. Colorado law requires we keep your original x-rays for 7 years.

Payment for services: We accept all major credit cards, checks, cash, and care credit. A $25 fee will be applied for returned checks.

We reserve the right to dismiss any patient from our office for inappropriate behavior in our office or over the phone.

I acknowledge that I am responsible to pay all charges for treatment as outlined above and that if my account is placed with a collection agency for non-payment that I will be responsible for all collection costs, including court costs and associated attorney fees.

I have read the policies and agree with the terms outlined above.

Responsible party signature: _____

Printed Name: _____

Date: _____

Dentistry at Happy Canyon 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 read 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. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect 5/1/2003, 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 given time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain. 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 this notice at any time.

Uses and Disclosures: We use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your health information to a physician, insurance company, 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.

Persons involved in care: We may use or disclose health information to notify a family member, your personal representative or another person responsible for your care of your location, your general condition, or death. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your health care.

Required by law: We may use or disclose your health information when we are required to do so by law.

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: If you are military personnel, we may disclose your health information to military authorities, federal officials, and lawful intelligence and counter intelligence officers under certain circumstances involving national security.

Appointment reminders: We may use or disclose your health information to provide you with an appointment reminder (such as post cards, letters, and phone messages)

Patient rights:
- You have the right to access, copy and inspect your health information
- The right to request an amendment to your health information if you feel there is incorrect information contained with your records.
- The right to obtain an accounting of certain disclosures of your health information.
- The right to request restrictions on disclosures for TPO.
- The right to alternate means of receiving communications from dentists
- The right to complain about alleged violations of the regulations and the dentists own information policies. The right to obtain a notice of privacy practices.

_____ _____

Signature of Patient or Legal Guardian Date

Dentistry at Happy Canyon Patient Consent for Use and Disclosure of Protected Health Information

With my consent, designated Dentistry at Happy Canyon personnel may disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPO).

Please refer to Dentistry at Happy Canyon Notice of Privacy Practices for a more complete description of such uses and disclosures.

I fully understand that I have the right to review the Notice of Privacy Acts Practices prior to signing this consent. Dentistry at Happy Canyon reserves the right to revise its Notice of Privacy Practices at any time.

With my consent, Dentistry at Happy Canyon personnel may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assists Dentistry at Happy Canyon personnel in carrying out TPO such as appointment reminders, insurance items, and any call pertaining to my clinical care.

With my consent, designated Dentistry at Happy Canyon personnel may mail to my home or other designated location any items that will assist designated Dentistry at Happy Canyon in carrying out treatment, payments, and health care options (TPO), such as appointment reminder emails, text messages, phone calls and statements. I have the right to request that Dentistry at Happy Canyon restrict how it uses or discloses my PHI to carry out my TPO. However Dentistry at Happy Canyon is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dentistry at Happy Canyon use and disclosures of my PHI to carry out my TPO. If I do not sign this consent, Dentistry at Happy Canyon may decline to provide treatment to, forward my insurance claims on my behalf, or provide protected PHI to sources outside of Dentistry at Happy Canyon.

_____

Signature of Patient or Legal Guardian

_____

Patient's Name

_____

Date