Chart #:_____
FOR OFFICE USE ONLY

C.S. FAMILY DENTAL, PLLC

6825 E. Hampden Ave. #101 Denver, CO 80224 (303) 756-3289

Patient Information

Patient Name: _____
Last First Middle

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ **Birth Date**:_____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell Phone): _____

Address: _____ E-mail: _____
Street APT #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for **TODAY's** visit:_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS / HIV
☐ Allergies
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Depression
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding

☐ Fainting
☐ Glaucoma
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis: Type ____
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Osteoporosis

☐ Pacemaker
☐ Pregnancy Due Date
_____
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease

☐ Others:
_____

** **Medicine Allergy**

☐ None
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Other Allergy:

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, **please explain**:_____
- Are you currently taking any prescription or non-prescription medications? ☐ Yes ☐ No
  If yes, **please explain**: _____
- Do you use tobacco products (smoking or chewing)? ☐ Yes ☐ No
  If yes, **please explain how many pack/day:** _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, **please explain When & Why**:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, **please explain**:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, **please explain**:_____

I hereby certify that I have read and understand all of the preceding answers and informations provided are true and accurate. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment (if patient is under 18)

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell Phone): _____

Address: _____ Email: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment Phone _____ Ext: _____

Company Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary Insurance: _____

Name of Subscriber: _____ Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Secondary Insurance: _____

Name of Subscriber: _____ Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone _____

Address: _____
Street City State Zip Code

How did you hear about us: ☐ Friend/Family ☐ Our Website ☐ Insurance Website ☐ Others: _____

Consent for Services / Financial Policy

This will enable you to know what services are planned, as well as, what your financial responsibility will be. Our financial policy is as follows:

(Initial) _____ I understand that the fee estimate of treatment listed for dental care can only be extended for a period of **six months** from the date of the patient examination. I understand that fee estimate can be changed if treatment has changed.

Insurance: If you have dental insurance, as a courtesy, we will be glad to assist you in filing your insurance claim. **Please keep in mind that ALL dental costs remain the responsibility of the patient and that all your dental costs may not covered 100% by insurance.** Because of this, and the extreme delay in receiving payment from the insurance company, we will ask you to pay the deductible, if any, and patient portion of the charges the day the service is scheduled. We will estimate, as closely as possible, patient's dental coverage, but until we actually receive the payment from the insurance company, it is just an **estimate**. We encourage ALL patients to review their dental benefits and communicate directly with their insurance provider.

(Initial) _____ If after 30 days, the insurance company hasn't paid, or you maximized your insurance benefit, the balance will be due, in full, by patient or guarantor of payment or responsible party.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

Broken appointment charge: Your appointment time is reserved exclusively for you. By giving us 48 hours (2 business day) notice of appointment changes or cancellation, we will be able to fill this time with other patients waiting for treatment. If 48 hours (2 business day) notice is not given, a $50.00 charge will be billed to the patient, unless a proof of excuse (for example, Doctor's note, or police report) is provided within 7 days of missed appointment date.
Late Arrival: If you are over 15 minutes late for your appointment, we reserve the right to reschedule your appointment for a later time or next available day. Please understand that we strive to stay on time for your appointment as well as those patients that follow you.

(Initial) _____ I understand that I need to pay any broken appointment fee promptly, if there's any before I make a next dental appointment.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the reasonable value of said services to the Doctor, or his assignee, at the time said services are rendered. 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 costs and reasonable attorney fees and/or collection agency fees if suit be instituted hereunder.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I authorize to C.S. Family Dental using my cell phone number and/or emergency contact's phone number to call or text, and receiving email communications regarding appointments, treatment, insurance, my account, and/or special promotions.

I have read and understood the all the policies and agree the said terms regarding payment for services, insurance policies, broken appointment charges, and communications with phone and email.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to patient: _____
Signature of guarantor of payment / responsible party (if patient is under 18)

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** HIPPA Privacy Authorization Form **

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW 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 about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect April 1st, 2006 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 time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. 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 our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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 or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health/Related Services: We will not use or sell your health information for marketing communications without your written authorization.

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: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, emails, postcards or letters)

Communication Method: By providing my contact information, I consent to receive communication via phone, text, and/or email regarding treatment, insurance, account, appointments, and special promotions.

Patient Rights Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the first page of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $20 per hour for staff time to locate and copy your health information, 50 cents for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 5 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, read of this office's Privacy Practices.
Patient, Parent or Guardian Name (**Please Print**)

_____

Patient, Parent or Guardian **Signature** Date Relationship with patient

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement 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 acknowledgement
☐ Other (please specify)

_____

Presented By:_____ Date:_____