PERFECT TEETH™

Today's Date ________________

Please give us some information....

THE ACCOUNT HOLDER/HEAD OF HOUSEHOLD

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ______________________________

Last Name First Name M.I.

Address ______________________________

Street City State Zip Code

Home Phone ______________ Cell ______________ Work ______________ E-mail ______________________

Birth Date __________________ Employer ______________________________

Employer's Address______________________________

Street City State Zip Code

Driver's Lic. #______________________________ OR Social Security # __________ - __________ -__________

THE PATIENT INFORMATION

MEDICAID ID # ____________________________

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ______________________________

Last Name First Name M.I.

Birth Date __________________ Relationship to Account Holder ______________________________

Would you like to learn more about options to pay for your dental treatment? ❑ Yes ❑ No

DENTAL INSURANCE

Insurance Co. ______________________________

Name Address City State Zip Code

Phone# ____________ Plan# ___________Group/Policy# ____________ID# ____________Effec. Date ____________

Name of Insured ______________________________Birth Date ____________________ Sex__________

Relationship to Patient____________________________ Social Security # __________– ___________– ___________

Insured's Address ______________________________

Street City State Zip Code

Insured's Employer ______________________________

Name Address City State Zip Code

Does this Policy Cover ❑ Spouse ❑ Children

ABOUT YOUR FAMILY

Name	Birth Date	Name	Birth Date

OTHER DENTAL INSURANCE

Insurance Co. ______________________________

Name Address City State Zip Code

Phone # __________________ Plan #________________ Group/Policy # ________________ Effec. Date __________

Name of Insured ______________________________Birth Date ____________________ Sex__________

Relationship to Patient____________________________ Social Security # __________– ___________– ___________

Insured's Address ______________________________

Street City State Zip Code

Insured's Employer ______________________________

Name Address City State Zip Code

Does this Policy Cover ❑ Spouse ❑ Children

HEALTH HISTORY

Patient Name ________________________________ **Medicaid ID #**____________________

It is important that we know about your medical history. Many things have a direct bearing on our health. We will review the questionnaire and discuss it with you in detail. Information you give us is strictly confidential and will not be released to anyone without your written permission.

Physician's name______________________________**Date of last physical examination**__________________

In case of emergency, notify ____ **Phone #**__________________

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

Yes No
- ❑ ❑ Heart Problems
- ❑ ❑ Heart Murmur
- ❑ ❑ High Blood Pressure
- ❑ ❑ Low Blood Pressure
- ❑ ❑ Bleeding Problems
- ❑ ❑ Anemia
- ❑ ❑ Bleeding Disorder
- ❑ ❑ AIDS/HIV
- ❑ ❑ Blood Transfusion

Date ________________
- ❑ ❑ Prosthetic Implants
- ❑ ❑ Musculoskeletal Issues
- ❑ ❑ Circulatory Problems

Yes No
- ❑ ❑ Stroke/TIA
- ❑ ❑ Pacemaker/Defibrillator
- ❑ ❑ Nervous System Problems
- ❑ ❑ MS/MD/Cerebral Palsy
- ❑ ❑ Epilepsy
- ❑ ❑ Diabetes (Circle: Type 1 Type 2)
- ❑ ❑ Dementia/Alzheimer's
- ❑ ❑ Psychiatric Care
- ❑ ❑ Lupus or other Connective Tissue Disease
- ❑ ❑ Kidney Disease ________
- ❑ ❑ Rheumatic/Scarlet Fever

Yes No
- ❑ ❑ Tuberculosis
- ❑ ❑ Emphysema/Chronic Bronchitis
- ❑ ❑ Asthma
- ❑ ❑ Lung/COPD Problems
- ❑ ❑ Arthritis _____________
- ❑ ❑ Thyroid Disorder
- ❑ ❑ Ulcers/Other GI Disease
- ❑ ❑ Liver Disease
- ❑ ❑ Hepatitis (circle: A B C D E)
- ❑ ❑ Herpes
- ❑ ❑ Cancer/Malignancies
- ❑ ❑ Sinus Problems
- ❑ ❑ Excessive Dry Mouth

Yes No
- ❑ ❑ Are You Pregnant or Could You Be
- ❑ ❑ Are You Nursing
- ❑ ❑ Oral Contraceptives
- ❑ ❑ Snoring and/or Sleep Apnea
- ❑ ❑ CPAP/O2 at Night
- ❑ ❑ Alcohol Use
- ❑ ❑ Drug Use
- ❑ ❑ Tobacco Use
- ❑ ❑ ADHD
- ❑ ❑ Autism
- ❑ ❑ Down Syndrome

Explanation of Above: ____

____

Medications: List ALL medications you are taking (prescribed or over the counter): ______________________________

____

Do you have any allergies (latex, anesthetics, penicillin, sulfa, codeine, etc.)? ❑ Yes ❑ No Explain: ________________________

____

Are you now, or have you ever taken a class of drugs called Bisphosphonates like Fosamax or Boniva for osteoporosis treatment?

❑ Yes ❑ No Explain:____

Have you had any clicking or discomfort in your jaw joints, and/or headache, neck, or back pain? ❑ Yes ❑ No Explain: __________

____

Have you or anyone in your family had any problems with anesthesia? ❑ Yes ❑ No Explain:__________________________

____

Are you currently under the care of a physician? ❑ Yes ❑ No Explain: ____________________________________

____

Physician's Name: ________________________________ Phone: ________________________________

Have you been hospitalized in the past 5 years? ❑ Yes ❑ No Explain:______________________________

____

Height: ____________ Weight:____________

Signature ____ **Date** ________________________

DENTIST HEALTH HISTORY INITIAL / UPDATES

Dates	By	Notes

REV 1/17

OFFICE POLICY

Payment will be expected at the time of service for all non-contracted 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, coinsurance, and 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. Further, if a member of our staff advises you that you are fully covered or implies that you will owe nothing, it is your responsibility to contact your insurance company for verification. Therefore, it is your responsibility to make certain your carrier makes prompt payment, and to handle any disputes that may arrive.

If your insurance has not paid the **FULL BALANCE** within 45 days from the date of service, you are asked to pay the balance in full. A finance charge of 18% APR (1.5% a month) will be added to the total balance on all accounts over 60 days past due.

Third party financing may be available for patients requiring extensive treatment ($800 or more). This type of financing must be approved in advance. The terms of this contract consist of six equal installments, free of interest or finance charges. The total financed amount however, must be paid in full within 12 months.

If at any time you have questions regarding any treatment, fees, or services, please discuss them with us promptly and frankly. 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 24 hours in advance. **The charge is $50 per hour of scheduled time.**

Children in the office: Please make arrangements for your non-scheduled children prior to your visit. Children should not be left unattended in the reception area. All children, 17 years of age and under, scheduled for treatment must have a parent or legal guardian present in the office during their appointment.

Cellular phones/pagers: We request all cellular phones and pagers be turned off or to silent mode during your appointment.

Family/Friends: In order to comply with regulations set by Perfect Teeth, and for the safety and comfort of our patients and employees, no friends or family members will be permitted to accompany patients in the treatment area during the appointment. Any patients with special needs can make necessary arrangements with the office manager prior to their appointment.

We reserve the right to dismiss any patient from our practice for excessive missed appointments, or for inappropriate behavior in our office or on the phone.

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

I acknowledge that I am responsible for payment of all charges for treatment administered by Perfect Teeth as outlined above.

Responsible Party Signature: ______________________________

Printed Name: ______________________________

Date: ____________________

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, designated Perfect Teeth personnel may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). This may include the use of phone calls, letters, emails, facsimiles, and text messages. Please refer to Perfect Teeth's 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 Practices prior to signing this consent. Perfect Teeth reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the designated Perfect Teeth HIPAA Compliance/Security Officer at Birner Dental Management Services, Inc., 1777 S. Harrison St. Suite 1400, Denver, CO 80210.

With my consent, Perfect Teeth personnel may mail to my home or other designated location any items that will assist Perfect Teeth in carrying out Treatment, Payment and Healthcare Operations (TPO), such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

When my information is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient that is outside of Perfect Teeth's control. If I do not sign this consent, Perfect Teeth may decline to provide treatment to me, forward insurance claims on my behalf, or provide PHI to necessary sources outside of the Perfect Teeth organization.

I have the right to revoke this authorization in writing except to the extent that Perfect Teeth has already made disclosures in reliance upon my prior consent. My written revocation must be forwarded to the designated Perfect Teeth HIPAA Compliance/Security Officer at Birner Dental Management Services, Inc., 1777 S. Harrison St. Suite 1400, Denver, CO 80210 to become legally effective and/or binding.

By signing this form, I am consenting to Perfect Teeth's use and disclosure of my PHI to carry out TPO.

______________________________	______________________________
Patient's Name	Legal Guardian's Name
______________________________	____________________
Signature of Patient or Legal Guardian	Date

MEDICAID ID # ______________________________

Patient Authorization for Practice to Release Protected Health Information to Third Parties

By signing this authorization, I authorize Perfect Teeth personnel to use and/or disclose certain **Protected Health Information (PHI)** about me to or for the party or parties necessary to complete **Treatment, Payment and Healthcare Operations (TPO)**.

This authorization permits Perfect Teeth to use or disclose the minimum necessary **Individually Identifiable Health Information (IIHI)** to complete my TPO. This authorization includes all IIHI and PHI unless restricted as delineated below.

I authorize Perfect Teeth to share my Protected Health Information (PHI) with:

☐ Spouse/Partner: ____

☐ Parent(s): ____

☐ Sibling/Other: ______________________________________ ________________________________
Relationship

Under no circumstances is my PHI to be shared with: ____

____

I authorize Perfect Teeth to email my PHI to: ____

____ I understand that this message may no longer be encrypted once it leaves Perfect Teeth's secure network.

I authorize Perfect Teeth to leave me a voicemail message at: ___________________________________

☐ Detailed (treatment and follow-up information, appointment time, etc.)

☐ General (no detailed information)

When my information is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Perfect Teeth has acted in reliance upon this authorization. My written revocation must be forwarded to the designated Perfect Teeth HIPAA Compliance/Security Officer at Birner Dental Management Services, Inc., 1777 S. Harrison St. Suite 1400, Denver, CO 80210 to become legally effective and/or binding.

I understand that this consent shall remain in effect until revoked in writing.

____ ____
Patient's Name Legal Guardian's Name

____ __________________________
Signature of Patient or Legal Guardian Date

MEDICAID ID # ______________________________

PERFECT TEETH

HELP US GET TO KNOW YOU BETTER!

Name ______________________________ Date ______________

By answering the following questions we will be able to better take care of your needs.

When was your last dental visit? ______________________________

Why did you leave your last dentist? ______________________________

Have you had any problems with previous dental treatment? Yes/No Explain: ______________________________

____

When was your last teeth cleaning? ______________________________

How did you hear about us? ______________________________

Rate Your Smile: ☺ 😐 ☹

Yes ❏ No ❏ Do you avoid brushing any part of your mouth?

Yes ❏ No ❏ Do your gums bleed when you brush?

Yes ❏ No ❏ Would you like to remove and replace any mercury/amalgam/silver fillings?

Yes ❏ No ❏ Are your teeth sensitive to sweets, hot/cold, or biting pressure?

Yes ❏ No ❏ Do you have any missing teeth?

Yes ❏ No ❏ Are you interested in replacing any of your missing teeth?*

Yes ❏ No ❏ Are you interested in solutions to improve your breath?

Yes ❏ No ❏ Does dental treatment make you nervous?

Yes ❏ No ❏ Would you like whiter teeth?

Yes ❏ No ❏ Would you like straighter teeth?*

Yes ❏ No ❏ Would you like to close spaces in your teeth?*

Yes ❏ No ❏ Would you like to repair chips in your teeth?

Yes ❏ No ❏ Have your wisdom teeth been extracted?

Yes ❏ No ❏ Do you have habits such as nail biting, pencil biting or lip biting?

Yes ❏ No ❏ Do you have habits such as thumb sucking or mouth breathing?

Yes ❏ No ❏ Do you clench or grind your teeth?

What is your biggest dental concern today? ______________________________

____

Lastly, if you could wave a magic wand, what would you want your teeth to look like? ______________________________

____

***Direct referral to specialist.**