Steele DENTISTRY

Preferred Name: ____________________________ DATE_________________________

PATIENT INFORAMTION

Patient's Name: First____________________________Last___________________________________Middle Initial________ Male Female

Address: ____City: ____________________State: __________Zip: _______________

DOB _________________Soc. Sec. #_______________________ Parent/Guardian Name (if patient is a minor) __________________________

Cell #_________________________Work or Home #___________________________Email____

How did you hear about us? **Insurance Yelp ZocDoc *5280* Walk/Drive By Front Porch Mailer Bagel Drop Internet search**

Friend/Family Member (please provide their name) ______________________________ **Other**_____________________________

EMERGENCY CONTACT

Name: First__________________ Last__________________ Relationship to Patient________________ Phone #______________________

DENTAL INSURANCE INFORMATION

Name of Insured____DOB__________________Soc. Sec. #____________________

Insurance Company __________________________Phone #____________________ID_______________________Group________________

SECONDARY INSURANCE

Name of Insured____DOB_____________________Soc. Sec. #__________________

Insurance Company ________________________Phone #______________________ID_______________________Group________________

DENTAL HISTORY	YES	NO
Do you have pain in any of your teeth?	☐	☐
Are you apprehensive about dental appointments?	☐	☐
Have you ever had a reaction to anesthetic?	☐	☐
Have you ever suffered trauma to your face or jaw?	☐	☐
Are your teeth sensitive to hot, cold, sweets, pressure?	☐	☐
Do your gums bleed, feel tender or irritated?	☐	☐
Do you wear dentures? (Partials or Full)	☐	☐
Are you unhappy with your dentures?	☐	☐
Do you snore?	☐	☐
Are you aware of grinding or clenching of teeth?	☐	☐
Do you have difficulty opening or closing your mouth?	☐	☐
Do you have face, muscle or TMJ/jaw pain?	☐	☐
Do you have headaches/migraines, earaches or neck pain?	☐	☐
Have you ever worn braces or Invisalign on your teeth?	☐	☐
Would you like your smile to look better or different?	☐	☐
Do you have discolored teeth that bother you?	☐	☐

Do you have an allergy to the following or any other allergies?

Aspirin Local Anesthetic Erythromycin Latex (Balloons, gloves, etc.)
Codeine Nitrous Oxide Penicillin Other___________

What would you change about your teeth? _______________________
____

Please rank the following in the order in which they would keep you from having dental treatment.
____Fear ___Lack of concern ____Cost ____Other

Is there anything else you would like us to know? _________________
____
____
____

I certify that the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

MEDICAL HISTORY	YES	NO
Are you under a physician's care now?	☐	☐
Reason: ____		
Have you been instructed to take antibiotics prior to a dental appointment?	☐	☐
What medications are you currently taking? ____________________ ____		
Have you ever used a Bisphosphonate Medication? (Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva)	☐	☐
Are you pregnant? Nursing? Taking birth control pills? (Circle all that apply)		
Do you use cigars/cigarettes/pipe/chewing tobacco/alcohol/marijuana/other drugs? (Circle all that apply)		

Please check any conditions that you have or have had:

AIDS/HIV Pos._______	Fainting__________	Psychiatric Care_________
Anaphylaxis________	Food allergies____	Rapid weight change_____
Anemia_____________	Glaucoma_______	Radiation Treatment_____
Arthritis____________	Headaches_______	Respiratory disease______
Artificial heart valves_	Heart murmur____	Rheumatic/Scarlet fever___
Artificial joints_______	Shingles_________	Heart problems (Please explain) _____________
Asthma_____________	Skin rash________	
Atopic (Allergy prone) _	Hemophilia______	Shortness of breath______
Back problems_______	Herpes__________	Spina Bifida____________
Blood disease_______	Hepatitis________	Stroke_________________
Cancer______________	Surgical Implant__	High blood pressure______
Jaw Pain____________	Tonsillitis_______	Chemical dependency____
Chemotherapy______	Epilepsy_________	Swelling of feet/ankles___
Circulatory Problems__	Kidney disease___	Thyroid disease_________
Cortisone treatments__	Liver disease_____	Material allergies________
Cough______________	Tuberculosis_____	Mitral valve prolapse ____
Cough up blood______	Ulcer/colitis______	Nervous problems_______
Diabetes____________	Venereal disease__	Pacemaker/heart surgery__

______________________________ ______________________________ __________________

Patient Name (PLEASE PRINT) **Patient (Parent/Guardian) Signature** **Date**

POLICIES & CONSENT

It is our pleasure to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

Fees for services will be requested at the time of your visit. We accept all major credit cards, Care Credit, checks and cash.

- For patients with dental insurance:

  Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. As a courtesy, we will file your initial claim for you at no charge, providing you have provided us with sufficient information; however, we ask that your deductibles and your estimated portions be paid as services are rendered. All account balances are ultimately your responsibility. Any balances remaining unpaid for 90 days will be turned over to collections

  - While we do understand the hesitation to provide your social security number, please be advised, we will not be able to file a claim on your behalf without it and all monies owed will be due at your time of service.
  - Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
  - If a claim must be re-filed a fee of $10.00 per re-filing will be billed to your account.
  - All insurance benefits are assigned to the doctor, unless services are paid in full the day of treatment.
  - Should your insurance coverage change, we do require 48 business hours' notice of this change prior to your appointment in order to utilize your new benefits for the scheduled appointment. If we do not receive 48 business hours' notice, you will be responsible for all charges the day of service. Once insurance has been verified a claim will be submitted.
  - Some of our providers are in-network while others are out-of-network. Regardless of which you see, you will only be charged the amount set by an in-network provider.
  - A $50 re-processing fee will be incurred each time an in-office payment plan payment is declined and a new payment plan needs to be established. This fee will be added to your balance owed.
  - There is a $35 fee for returned checks.
  - We will gladly bill your primary and secondary insurance on your behalf. Any insurance beyond that is the patient's responsibility.
- **If you must reschedule or cancel an appointment, we require advanced notice of 48 business hours. Cancellations, last minute rescheduling or failure to show without 48 business hours' notice will result in a fee of $75.00 or up to 50% of the appointment total and no reappointments if repeated. If more than one family member is scheduled & fails to make their appointment this same policy will be assessed for EACH family member. This policy is strictly enforced. Please be courteous and conscientious of this policy as your appointment time is set aside especially for you.**
- As a courtesy, our office will provide confirmation calls, emails and reminder cards to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm your appointment. Failure confirm your appointment may result in your appointment needing to be rescheduled.
- We realize that many families are in a state of change. The parent/guardian who is listed as the contact and/or responsible party will be held liable for all fees incurred.
- The charge for emailing medical/dental records as set forth by the Code of Colorado Regulations: 5.2.3.4 - The discharged patient or representative shall pay the reasonable cost of obtaining a copy of his/her records, not to exceed $15.00 including radiographs. Payment is due prior to records being released.
- Payment of the full estimated patient portion is required before treatment appointments can be scheduled.
- Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account. A monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due accounts.

I have read and understand all the above information. The undersigned hereby authorizes Steele Dentistry to perform any diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the doctor at the next appointment. For insured patients, my signature below also authorizes assignment of insurance benefits to the doctor and authorizes the release of dental records to my insurance company.

____

Patient Name (PLEASE PRINT)

____ ________________________

Patient (Parent/Guardian) Signature Date

This notice describes how medical/dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 303-278-3353.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Steele Dentistry does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment. By signing below, you and Steele Dentistry agree to not post anything confidential or of a personal matter on the internet.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Steele Dentistry maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Steele Dentistry.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Steele Dentistry occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

I ____have reviewed and agree to Steele Dentistry's Privacy Policy.

Please Print Patient Name

____ _____________________

Patient (Parent/Guardian) Signature Date