



Preferred Name: \_\_\_\_\_

DATE \_\_\_\_\_

**PATIENT INFORMATION**

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?	<input type="checkbox"/>	<input type="checkbox"/>
Are you apprehensive about dental appointments?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a reaction to anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever suffered trauma to your face or jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot, cold, sweets, pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed, feel tender or irritated?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures? (Partials or Full)	<input type="checkbox"/>	<input type="checkbox"/>
Are you unhappy with your dentures?	<input type="checkbox"/>	<input type="checkbox"/>
Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of grinding or clenching of teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty opening or closing your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have face, muscle or TMJ/jaw pain?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have headaches/migraines, earaches or neck pain?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever worn braces or Invisalign on your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your smile to look better or different?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have discolored teeth that bother you?	<input type="checkbox"/>	<input type="checkbox"/>

**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?	<input type="checkbox"/>	<input type="checkbox"/>
Reason: _____		
Have you been instructed to take antibiotics prior to a dental appointment?	<input type="checkbox"/>	<input type="checkbox"/>
What medications are you currently taking? _____		
_____		
Have you ever used a Bisphosphonate Medication? (Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva)	<input type="checkbox"/>	<input type="checkbox"/>
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)		
<b>Please check any conditions that you have or have had:</b>		
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 _____	Shortness of breath _____
Atopic (Allergy prone) _____	Hemophilia _____	Spina Bifida _____
Back problems _____	Herpes _____	Stroke _____
Blood disease _____	Hepatitis _____	High blood pressure _____
Cancer _____	Surgical Implant _____	Chemical dependency _____
Jaw Pain _____	Tonsillitis _____	Swelling of feet/ankles _____
Chemotherapy _____	Epilepsy _____	Thyroid disease _____
Circulatory Problems _____	Kidney disease _____	Material allergies _____
Cortisone treatments _____	Liver disease _____	Mitral valve prolapse _____
Cough _____	Tuberculosis _____	Nervous problems _____
Cough up blood _____	Ulcer/colitis _____	Pacemaker/heart surgery _____
Diabetes _____	Venereal disease _____	

Patient Name (PLEASE PRINT)

Patient (Parent/Guardian) Signature

Date

Doctor initials: \_\_\_\_\_



***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



## **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. Any and 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 33% 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 requests treatment for a child is responsible 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.
- Treatment appointments made will require a deposit of 1/3 down or \$75.00, which ever amount is greater, to hold the appointed time.
- 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