Preferred Name: _____ Steele DENTISTRY 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

What do you like about your teeth? _____

_____

_____

Which of the following are important to you regarding your teeth? (Circle all that apply.)

Look Good Feel Good Last a Long Time

Why are these important to you? _____

_____

_____

Which of the following might keep you away from the dentist? (Circle all that apply.)

Lack of Concern Cost Fear Lack of time Other_____

Is it important to you that your dentistry lasts a long time? YES NO

Is there anything else you would like us to know? _____

_____

_____

_____

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? (for bone density) (Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva)	☐	☐
Are you taking a blood thinner? (Xarelto, Warfarin, Eliquis, Coumadin, Heparin, etc.)	☐	☐
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.)	☐ None	

Do you have any allergies? ☐ None

Aspirin Local Anesthetic Erythromycin Latex

Codeine Nitrous Oxide Penicillin Other_____

Please check any conditions that you have or have had:

AIDS/HIV Pos._____	Heart murmur____	Radiation Treatment_____
Artificial heart valves___	Hemophilia_____	Respiratory disease_____
Artificial joints_____	Herpes_____	Asthma_____
High blood pressure_____	Hepatitis_____	Shortness of breath_____
Blood disease_____	Liver disease_____	Cancer/Tumor_____
Chemotherapy _____	Epilepsy _____	Diabetes_____
Cortisone treatments__	Tuberculosis_____	Stroke_____
Kidney disease___	Mitral valve prolapse ____	Pacemaker/heart surgery__
Heart problems (Please explain) _____		
History of infective endocarditis _____		
Heart transplant _____	Congenital Heart Disease _____	

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

_____ _____ _____

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

Steele
DENTISTRY

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 for hygiene and at the time of scheduling for treatment.** We accept all major credit cards, Care Credit, checks and cash.

- For patients with dental insurance:
  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 or treatment is scheduled. 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.
  - Please be advised: Steele Dentistry believes in offering dentistry that will last a long time. Insurance companies will occasionally deny a service because they are willing to pay only for the least expensive option which is usually not in the best interest of the patient. This can result in a higher cost for the patient if insurance refuses to pay their anticipated portion.
  - If a claim must be re-filed a fee of $10.00 per re-filing will be billed to your account. Accounts needing excessive administrative work will be billed at $55 per hour. Any exorbitant lab fees or chair time will be due from the patient.
  - Should your insurance coverage change, we do require 48 business hours' notice prior to your 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. You will be reimbursed once we receive full payment from your insurance company.
  - 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.
  - Patient portions are only an **estimate** based on limited information provided by your insurance company. You are obligated to any portion not paid by your insurance.
- **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 automatically charged to your credit/debit card 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, texts, 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 to confirm your appointment may result in your appointment needing to be rescheduled.
- I understand that if I choose to switch providers or move from the area mid-treatment, no refund will be given. I understand that if I decide to stop treatment mid-way, no refund will be given.
- 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.
- I understand that Steele Dentistry email is not encrypted, and any information sent to or received by them is potentially at risk. When possible, all sensitive documentation should be sent in the mail or given in person.
- I understand that a minimum of $4,400 must be collected from insurance and/or myself for comprehensive orthodontics and $2,400 for limited orthodontics.
- Any collection fees, court costs, or reasonable attorney 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