# Welcome to Our Office!

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask and we would be happy to help.

## PATIENT INFORMATION

**Your legal name** (this is your name on legal documents and medical records)

First _____ MI _____ Last _____

**Name** your providers should use (if same as your legal name leave this blank)

Name: _____

Sex assigned at birth (this is the sex you were designated as a baby)
Female_____ Male_____ Intersex_____

Gender identity.
__Woman (trans or cis) __ Man (trans or cis) __ Non binary __ Transgender__ Other.

Pronouns.
____she/her/hers ____he/him/his ____they/them/theirs ____ another set of pronouns

Birth Date _____SS# _____
Address _____ City_____ State _____ Zip _____
Email Address _____
Home Phone _____ CellPhone _____
Spouse/Significant other or Parent's Name _____Phone _____
Emergency Contact _____ Phone _____

Pharmacy Preference:_____ Location: _____

How did you hear about our office? (Circle all that apply)
TV | Google | Website | Drive By | Friend | Patient/Other _____

## INSURANCE INFORMATION

Insurance Company _____ Customer Service Phone _____
Group/ Policy _____ ID _____

*Fill the section below if you are a dependent on the policy:*
Policy Holder _____ Policy Holder DOB _____
Policy Holder SS# _____

## CONTACT INFORMATION

Consent to email or text usage for appointment reminders include: email, calls, and/or text messaging to remind you of an appointment, obtain feedback on your experience with our healthcare team, and to provide general health reminders/ information. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan.

[ ] **Accept** I authorize Red Rocks Family Dentistry to contact me at the phone numbers, emails, and any additional contact information provided to the office.

[ ] **Decline** I do not wish to receive text messages and/or emails from the practice. I request all communications be done through phone calls only.

Please keep in mind if your cell phone number is linked to other accounts, you may get messages about their appointments as well.

_____ _____

Patient/Legal Guardian Signature Date

# HEALTH HISTORY

Name:_____ DOB: _____

Please describe your current health:
Excellent Good Fair Poor

Please describe the symptoms you are currently having:

_____

Date of last physical exam ____ / ____ / ____
Have you ever been hospitalized or had a serious illness? Yes No
If yes, why?_____
Have you ever had surgery? Yes No
If yes, when and what for?
Dates:_____
Reasons:_____

**PATIENT MEDICAL HISTORY**

Heart/Cardiovascular Disease (heart attack/murmur, coronary artery disease, chest pain, stroke, pacemaker, heart valve replacement) Y N
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee) Y N
Lung Disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing) Y N
High/Low Blood Pressure Y N
Kidney Disease/Kidney Failure Y N
Thyroid Disease Y N
Liver disease (Hepatitis A, B, C) Y N
Bleeding disorder, anemia, bleeding tendency, blood transfusion,bruise easily Y N
Arthritis Y N
Sinus Problems/ Sleep Apnea Y N
Osteoporosis/ Osteopenia Y N
Stomach Ulcers/ Colitis Y N
Diabetes Y N
Seizures/ Epilepsy/ Dizziness Y N

Are you pregnant, or is there any chance you might be pregnant? Yes No N/A

**DENTAL HISTORY**

- ❏ Frequent or recurring mouth sores
- ❏ Sensitivity
- ❏ Bleeding of the gums
- ❏ History of periodontal therapy
- ❏ Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth
- ❏ Clenching or Grinding

Do you like your smile? Yes No

**SOCIAL HISTORY**

Do you smoke, vape or chew tobacco?
Yes No
If yes, for how long?_____
Have you ever sought professional care or been hospitalized for:

| | | |
|---|---|---|
| Substance abuse | Y | N |
| Emotional disorders | Y | N |
| Alcoholism | Y | N |

Do you use:

| | | |
|---|---|---|
| Alcohol | Y | N |
| Marijuana | Y | N |
| Recreational drugs | Y | N |

**ALLERGIES**

Are you allergic to any of the following?

| | | |
|---|---|---|
| Penicillin | Y | N |
| Aspirin | Y | N |
| Codeine | Y | N |
| Anesthetics | Y | N |
| Acrylic / Metal | Y | N |
| Latex | Y | N |

Allergic to anything not listed? _____

**MEDICATIONS**

Are you using any of the following?

| | | |
|---|---|---|
| Antibiotics | Y | N |
| Anticoagulants (blood thinners) | Y | N |
| Heart Medications | Y | N |
| Steroids | Y | N |
| Antianxiety/ Antidepressants | Y | N |
| Prescription Pain Medication | Y | N |
| Blood Pressure Medications | Y | N |
| Bisphosphonates | Y | N |

Please list any specific medications (including dosage) indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

_____
_____
_____
_____
_____

**I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct**.

_____ _____
Patient/Legal Guardian Signature Date

_____
Printed name of Patient/Legal Guardian

*Office Use Only*

**HEALTH HISTORY UPDATE**

| Updates | Date | Doctor Signature |
|---|---|---|
| _____ | _____ | |
| _____ | _____ | |
| _____ | _____ | |
| _____ | _____ | |
| _____ | _____ | |
| _____ | _____ | |

No history change Sign and Date _____ No history change Sign and Date _____

No history change Sign and Date _____ No history change Sign and Date _____

# GENERAL CONSENT FORM

Name:_____ DOB: _____

**Consent to Treatment:** **Please read and understand the following.**

I do hereby authorize and request the performance of dental services and the use of procedures Dr. Damian or Dr. Freiberg may deem necessary for treatment. I understand that Drs. Damian or Dr. Freiberg and their staff will use clinical and patient management techniques that are reasonable, necessary, and advisable. I understand that potential complications include, but are not limited to pain, swelling, bruising, temporary limited opening, and local infection. I understand that in occasional cases the anesthesia may be prolonged and in very rare cases permanent.

I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since the initial examination and extent of dental pathology. Once the treatment plan has been started, complications may arise that dictate additional procedures or treatment. I'll be advised of any changes.

In the event that Drs. Damian, Dr. Freiberg, or a staff member is exposed to my blood or other bodily fluids, I agree to have my blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C virus (HCV), and human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and the person would be advised of his/her rights regarding protected health information.

In some cases, teeth can respond negatively to even the smallest dental treatment and may require more treatment (root canal, extraction, crowns) that is unexpected or unforeseen.

**I understand that dental treatment is basically surgery on my tooth and may cause post operative sensitivity for a period of time.** I understand that minor adjustments may be necessary after treatment for better comfort.

**Signature:**

_____ Patient/Legal Guardian Signature Date_____

_____ For Guardians, please note your relationship to the patient.

_____ Doctor

YOU MAY REQUEST A COPY OF THIS CONSENT

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# HIPAA AUTHORIZATION AND RELEASE FORM

Name:_____ DOB: _____

## Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Parent/ Spouse _____

[ ] Child(ren): _____

[ ] Other _____

[ ] Information should not be released to anyone.

## Privacy Practices and Consents

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION

_____ _____

Print Patient Name Date

I,_____, have read this notice and have
Patient/ Legal Guardian Signature
been informed that I may request a copy of this office's NOTICE OF PRIVACY PRACTICES, as required by federal law. As well as, consent to the use and disclosure of my personal health information by your office during treatment, billing/payment and healthcare operations as outlined in the Notice of Privacy Practices.

## Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at al alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the US Department of Health and Human Services. A Privacy/Contact officer has been designated for this office. Please ask our front desk personnel and they will direct you to the Privacy/Contact Officer.

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# FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. I understand that charges for care provided to me will depend on what treatment is necessary for us to provide appropriate, quality dental care. All bills are subject to review by qualified billing and coding professionals, who may determine that additional charges or a refund may be due;thus, initial charges may not reflect my final bill.

**Any patient portion must be paid in full at the time of service.**

- We accept cash, check, Visa, MasterCard, Discover and American Express.
- We offer financing through CareCredit.
- There will be a $30.00 charge for returned checks.

## Payment Agreement

I accept full financial responsibility for the treatment performed by this office. Insurance forms will be completed as a convenience to the patients, however, payment to Red Rocks Family Dentistry is expected at the time services are rendered. Should the services of an attorney be required for collection of this account, I agree to pay reasonable attorney's fees, court costs, and other costs of collection.

In regard to treatment of minors, a divorced parent/legal guardian who accompanies a minor and gives permission for treatment is responsible for payment. This applies even if another parent/legal guardian has been determined by court settlement to be financially responsible. Both parents are jointly responsible for minor's dental charges.

## Regarding Insurance

Most insurance companies set reimbursements that are at or below our fees after co-payments, however, you are still responsible for the full amount of the bill. Insurance is a contract between you and your insurance company. We will not become involved in disputes between the two regarding deductibles, co-payments, charges, "usual & customary" charges, etc. other than to supply factual information if necessary.
I understand the treatment planned for me and authorize the release of any information related to my insurance claim. I also authorize group insurance benefits to me to be paid directly to Red Rocks Family Dentistry.

## Cancellation Policy

As a courtesy to the providers, I acknowledge I may be subject to a **$50 charge** for a missed, cancelled, or rescheduled appointment when providing less than a 24 HOUR BUSINESS DAY notice.

_____ _____

Patient Name/Legal Guardian Signature Date