PATIENT INFORMATION

Today's Date ____________________

Patient Name ____________________ Birthdate ____________________

Home Address ____________________

City ____________________ State ____________ Zip ________ Email ____________________

Home Phone ____________________ Cell Phone ____________________ Work Phone ____________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer ____________________ Employer Phone ____________________

Employer Address ____________________

City ____________________ State ____________ Zip ________

Spouse or Parent's Name ____________________ Birthdate ____________________

Home Phone ____________________ Cell Phone ____________________ Work Phone ____________________

Spouse or Parent's Employer ____________________

Employer Address ____________________

City ____________________ State ____________ Zip ________ Email ____________________

If patient is a student, name of school/college ____________________ City ____________________

Emergency Contact ____________________ Relation ____________________ Phone ____________________

Whom may we thank for referring you? ____________________

RESPONSIBLE PARTY

Person Responsible for this Account ____________________ Birthdate ____________________

Relationship to Patient ____________________ SS# ____________________ Email ____________________

Address ____________________

City ____________________ State ____________ Zip ________

Home Phone ____________________ Cell Phone ____________________ Work Phone ____________________

Employer ____________________ Employer Phone ____________________

Employer Address ____________________

City ____________________ State ____________ Zip ________

Is this person currently a patient in our office? ☐ Yes ☐ No

DENTAL INSURANCE INFORMATION

Name of Insured ____________________ Birth date ____________________

Relationship to Patient ____________________ SS# ____________________ Email ____________________

Is Insurance Through Employer? ☐ Yes ☐ No

If Yes, Name of Employer ____________________

Insurance Company ____________________ Group# ____________ Insurance ID# ____________________

Do you have additional dental insurance? ☐ Yes ☐ No

If yes, complete the following:

Name of Insured ____________________ Birth date ____________________

Relationship to Patient ____________________ SS# ____________________ Email ____________________

Is Insurance Through Employer? ☐ Yes ☐ No

If Yes, Name of Employer ____________________

Insurance Company ____________________ Group# ____________ Insurance ID# ____________________

PATIENT INFORMATION

Today's Date ____________________

Patient Name ____________________ Birthdate ____________________

Home Address ____________________

City ____________________ State ____________ Zip ________ Email ____________________

Home Phone ____________________ Cell Phone ____________________ Work Phone ____________________

PATIENT MEDICAL / DENTAL HISTORY

Physician ____________________ Phone ____________________ Date of last exam ____________________

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medications including over the counter medicines and vitamins?	☐	☐

If yes, what are you taking? ____________________

____

	YES	NO
4. Do you use tobacco?	☐	☐

What type? ____________________

5. How much alcohol do you consume? ____________________

	YES	NO
6. Have you had any addictions to alcohol or medications?	☐	☐
7. Are you allergic to or have you had any reactions to any drugs?	☐	☐

If yes, please specify ____________________

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8. Women Only:

	YES	NO
A) Are you pregnant or think you may be pregnant?	☐	☐
B) Are you nursing?	☐	☐
C) Are you taking birth control pills?	☐	☐

Please indicate which of the following applies to you. Check only if the answer is yes.

☐ High Blood Pressure	☐ Asthma	☐ Liver Disease	☐ Hepatitis or Jaundice
☐ Low Blood Pressure	☐ Heart Murmur	☐ Cancer	☐ Arthritis
☐ Heart Disease	☐ Joint Replacement / Implant	☐ Rheumatic Fever	☐ Diabetes
☐ Angina	☐ Leukemia	☐ Emphysema	☐ AIDS or HIV Infection
☐ Heart Attack	☐ Swollen Ankles	☐ Cdd Sores / Fever Blisters	☐ Fainting / Seizures
☐ Heart Trouble	☐ Epilepsy I Convulsions	☐ Anemia	☐ Frequently Tired
☐ Chest Pains	☐ Easily Winded	☐ Stroke	☐ Hay Fever / Allergies
☐ Cardiac Pacemaker	☐ Tuberculosis	☐ Radiation Therapy	☐ Other ____________
☐ Blood Thinners	☐ Respiratory Problems	☐ Bleeding Problems	____________
☐ Kidney Diseases	☐ Sexually Transmitted Diseases	☐ Recent Weight Loss	____________
☐ Stomach Troubles / Ulcers	☐ Thyroid Problem	☐ Glaucoma	____________

COMMENTS

____

____

Check only if the answer is yes.

1. Do your gums bleed while brushing or flossing? ☐
2. Have you ever been told that you have gum disease? ☐
3. Have you ever had Root Debridement and Scaling? ☐
4. Have you had gum / bone surgery? ☐
5. Do you feel pain in any of your teeth? ☐
6. Do you have any sores or lumps in or near your mouth? ☐
7. Have you had any head, neck or jaw injuries? ☐
8. Have you ever experienced any of the following problems in your jaw?
   ☐ Clicking? ☐ Pain (Joint, ear, side of face)?
   ☐ Difficulty in opening or closing? ☐ Difficulty in chewing?
   ☐ Waking up with headache or jaw tenderness?
9. Do you have frequent headaches? ☐
10. Do you clench or grind your teeth? ☐
11. Do you bite your lips or cheeks frequently? ☐
12. Have you ever had any difficult extractions in the past? ☐
13. Have you had any orthodontic work? ☐
14. Have you ever had prolonged bleeding following extractions? ☐
15. Have you ever had instruction on the correct method of brushing your teeth? ☐
16. Have you ever had instruction on the care of your gums? ☐
17. Are your teeth sensitive to: (Mark all that apply)
    ☐ hot ☐ cold ☐ sweet ☐ sour ☐ liquids / hard foods?

I certify that I have read and understand the above information. To the best of my know edge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient, Parent or Guardian ____________________ Date ____________

Consent for Services

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids appropriate for a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform treatment mutually agreed upon and to use medication and therapy indicated for such treatment in connection with (name of patient) ____. I understand that anesthetic agents involve a certain risk. Furthermore, I authorize doctor to choose and employ assistance as deemed fit to provide treatment.
3. I understand that responsibility for payment of services -- for me, or my dependents -- is mine, due and payable at the time services are given unless other arrangements are made. In the event that payments are not received as agreed upon a monthly 1 % finance charge may be added to my account.
4. I understand that, if needed, a credit report may be obtained. If my account goes to collections, a minimum fee of $50, or 5% of the total deliquent balance, will be charged to cover collection expenses.
5. I understand it is my responsibility to advise of any changes regarding my name, residence, phone numbers, dependents, employer, or insurance benefits. I grant permission to doctor, or staff to phone me at home, or work to discuss matters related to this information.

I have read the above conditions and agree to their content.

Signature: ____ Date: __________________ Relationship to Patient: _________________________
(of patient, parent, or guardian)

Date of Service:	*Type of Service:*	*Patient Signature:*

The results of dental treatment are not always predictable. Reputable practitioners cannot guarantee results. I acknowledge that no guarantee has been made by anyone regarding treatment I have authorized. I also understand my treating dentist is responsible for my treatment and that alternatives -- including no treatment -- have been discussed and are understood.

Rocky Mountain Dental Care
Financial Guidelines

THANK YOU FOR CHOOSING US AS YOUR DENTAL HEALTHCARE PROVIDER. Dr. Johnson and his staff are dedicated to serving your dental needs with the best professional advice, care, and service obtainable. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy and guidelines, which we require you to read and sign prior to any treatment. We are glad that you are here and we want to do our very best for you. If you have any questions during your dental exam or treatment, please feel free to ask.

PRIVATE PAY PATIENTS

Full payment is due at the time of service unless prior arrangements have been made. We accept cash, checks, Visa, Mastercard, Discover, American Express, Care Credit, and debit cards. Ask us about interest free financing through Care Credit or Citicards.

INSURANCE PLANS

We will always do our best to help you to maximize your benefits. Your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract and cannot predict or guarantee any insurance coverage or benefits.

Your treatment plan is individually tailored and is not based on your dental insurance benefits or lack of benefits.

Not all services are covered benefits in all contracts. Most insurance plans arbitrarily select certain services they will not cover. The coverage your employer purchases from the insurance company may only cover the least expensive treatment, which may not be the most appropriate treatment for you. You are responsible for paying for your treatment, whether your insurance deems it covered or not. It is your responsibility to thoroughly understand the coverage, exceptions, yearly maximums, etc. of your particular policy.

As a courtesy to all of our insured patients, we will file your dental insurance claim forms for you. You are responsible at the time of treatment for payment to us of any applicable deductible and for your co-insurance portion. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately to our office so that your account may be credited accordingly. Accruing interest at the rate of 1.5% monthly can be avoided if your personal financial responsibility is cleared within 90 days of your treatment.

Your claim will be filed immediately, and benefits are expected to be paid by your insurance within 30 days. The payment or non-payment of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 60 days, the unpaid portion will automatically become “self pay” and a statement will be issued to you for the unpaid portion. Please feel free to contact your insurance company regarding unpaid benefits.

I understand and accept the financial and the dental insurance policies and guidelines listed above. I agree to pay for all treatment in a timely fashion as described so as to avoid any additional fees. I hereby authorize my insurance benefits to be paid directly to Dr. Johnson.

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PATIENT (or parent of minor) Date

Rocky Mountain Dental Care
Course of Action for
"No Shows"

A "No Show" occurs when a patient does not arrive for his or her scheduled appointment and does not call 48 hours in advance to cancel or reschedule the appointment. A "No Show" wastes both time and resources of the Doctor, Hygienist, and office staff, and also prevents another patient from utilizing that appointment time.

As a courtesy to you, we send reminder cards two to three weeks before scheduled appointments. Additionally, we call you to get verbal confirmation of all appointments. If a "No Show" still occurs, Rocky Mountain Dental Care has no other recourse but to charge a fee for it. The fee is $40.00. The purpose of the fee is twofold: primarily, it is to recoup some of the lost office overhead expenses; second, it is a reminder to call in advance to reschedule an appointment should something unavoidable arise.

Generally, we track "No Shows", and after the third, our policy is to discharge you from our care. Obviously, we would prefer that you call ahead if something comes up such that you are unable to keep your appointment, thus avoiding a "No Show".

We thank you for your understanding in this matter, and appreciate your cooperation.

I understand, accept, and agree to the above guidelines for No Shows.

____

Patient (or parent of minor) Date

Rocky Mountain Dental Care

Leslie Johnson, DDS

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Rocky Mountain Dental Care we have always kept your health information secure and confidential. HIPPA law requires us to maintain your privacy and to give this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment.

We may use or disclose your health information for payment of services. For example, we may send a report to your insurance company.

We may use or disclose health information to other healthcare providers in connection with your treatment, to third party payors or spouses, to other patients or parties who may see or overhear incidental disclosures about your treatment, scheduling, etc., and to your family or close friends involved in your treatment.

We may use your information to contact you. For example, we may send text or email reminders for your appointments. We may also leave appointment information with a person, or on your voicemail should you not be available.

We may release your information when required by law.

If this dental practice is sold, your information will be given to the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. If you request a copy of your records, this must be done in writing and a reasonable fee may be charged.

Our HIPPA Privacy policy is available for you to review, should you request it. This notice has been in effect since April 14, 2003.

Acknowledgement:

I have read this Notice of Privacy Practices and give my consent.

Patient (or guardian) Printed Name: ____

Signature: ______________________________________ Date: ________________