Patient Registration Form

Patient ____
First Name Initial Last Name

Address ____

City ______________________ State ____________ Zip ____________

Home Phone ______________ Work ________________ Cell ____________

Email Address ____________________ DOB __________ SS# ____________

Emergency Contact

Name ______________________________ Relation ____________________

Phone number ____________________ Phone number ____________________

General Dentist

Name ______________________________ Phone ____________________

Dental Insurance Information

Subscribers Name ______________ Social Security ____________ DOB ________

Insurance Company ____________________ Plan Name ____________________

Employer ____

Secondary Dental Insurance Information

Subscribers Name ____________________ Social Security ________________

Insurance Company ____________________ Plan Name ____________________

Employer ____

Please read the following and sign:

Dental insurance plans do not normally provide full coverage of your dental bill. There is a charge for your consultation in our office. Your dental coverage is a contract between you and your insurance company, and while we will cooperate to the fullest in expediting your claim, you are ultimately responsible for your account. Your portion of the bill will be due at time of service.

If your insurance has not paid within 60 days from the date of service, we will look to your for prompt payment of the account. All costs for collection of the account, should collection procedures or small claims court become necessary, will be passed on to the patient and/or the responsible party. I understand that, due to any false information, I will be subject to criminal prosecution

______________________ ______________________________

Date **Signature of Patient (responsible party of minor)**

MEDICAL / DENTAL HISTORY FORM

Patient Name____

Your answers are for our records only and will be considered confidential.

Do you have or have you had any of the following?

Heart disease / heart attack	NO	YES	Diabetes/Prediabetes	NO	YES
Artificial heart valve/ congenital heart defect	NO	YES	Osteoporosis	NO	YES
Pacemaker	NO	YES	Radiation or chemotherapy	NO	YES
High or low blood pressure	NO	YES	Bone cancer or bone disease	NO	YES
Chest pains or angina	NO	YES	Sinus problems	NO	YES
Stroke	NO	YES	Kidney disease	NO	YES
Artificial joint	NO	YES	Asthma	NO	YES
Excessive or prolonged bleeding	NO	YES	Arthritis	NO	YES
HIV or other immunosupressive disease	NO	YES	Tuberculosis (TB)	NO	YES
Hepatitis / Liver disease	NO	YES			

Do you have, or have you had any disease, condition or problem not listed above? NO YES
If yes, Please explain:

Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, amoxicillin, aspirin, codeine, hydrocodone, vicodin, local anesthetic or any drugs or medications? NO YES

Do you currently smoke or use tobacco? NO YES

Have you ever smoked or used tobacco? NO YES

Have you ever been told to take antibiotics or to premedicate prior to dental appointments? NO YES

Do you use recreational drugs? NO YES

Have you been a patient in the hospital during the past five years? NO YES

Have you been under the care of a physician during the past two years? NO YES

Are you currently under the care of a physician(s)? NO YES

When were you last seen by a physician?____

Name of physician____

Street Address____

Phone____

Women only:

Are you nursing or pregnant? NO YES

Are you taking birth control pills? NO YES

LIST OF MEDICATIONS - taken within the last 2 years

DRUG NAME	DOSE / FREQUENCY	REASON FOR TAKING	CURRENTLY TAKING
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N

Are you taking any over the counter medications (ie Aspirin, Tylenol, Ibuprofen) or herbal medications? NO YES
If yes, Please list above

Have you taken any steroid medications (ie prednisone) in the past two years NO YES

Have you ever taken any oral or IV bisphosphonates (for treatment of osteoporosis or bone cancer) such as Fosamax (alendronate), Actonel (risedronate), Atelvia, Boniva (ibandronate), Reclast, Zometa, Didronel, Aclasta, Aredia, or Skelid? NO YES

Please sign below to attest that the information provided is complete and correct.

______________________________ ______________________________

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

DENTAL HISTORY

Aurora Periodontics and Implant Dentistry

What is the reason for your visit to the periodontist? Please describe below.

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Are you having pain or discomfort at this time? NO YES

Do you feel nervous about dental treatment? NO YES

Have you ever had a bad experience in a dental office? NO YES

Do you or have you been told that you grind or clench your teeth? NO YES

How often do you brush (please circle)? Less than once a day Once a day Twice a day More than twice a day

How many times a week do you floss (please circle)? 0 times 1 time 2 times greater than 3 times

When was your last regular cleaning? ____

Have you had a deep cleaning where your dentist/hygienist numbed your gums (scaling & root planing)? NO YES

If yes, please list when ____

Have you ever had periodontal (gum) surgery in the past? NO YES

(a) Do you remember what treatment you had? If so, please describe.

(b) How long ago did you receive this/these treatment(s)?________________________________

Has anyone else in your family been diagnosed with periodontal (gum) disease? NO YES

Do you have any other concerns you wish to speak about? NO YES

If so, please describe.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may—but are not required to—prepare a summary or an explanation of your health
information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:
- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations, you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. 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 or with the U.S. Department of Health and Human Services.

CONTACT OFFICER:

Eric Anderson, DDS, MS
20971 E Smoky Hill Rd #202
Centennial, CO 80015
P 303-400-1100, F 303-400-4422

I, ____, have had full opportunity to read & consider the contents of this Consent Form. I understand that, by signing this form, I am giving my consent to the Aurora Periodontics & Implant Dentistry's use & disclosure of my protected health information to carry out treatment, payment activities & health care operations.

____________________________________ ______________________________

Signature Date

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

____________________________________ ______________________________

Personal Representative's Name Relationship To Patient

OFFICE POLICIES

Office Financial Policies

Dental insurance plans do not normally provide full coverage of your dental bill. There is a charge for your consultation in our office. Your dental coverage is a contract between you and your insurance provider, and while we will cooperate to the fullest in expediting your claim, you are ultimately responsible for your account. **Your portion of the bill will be due at time of service**.

If your insurance has not paid within 60 days from the date of service, we will look to you for prompt payment of the account. All costs for collection of the account, should collection procedures or small claims court become necessary, will be passed on to the patient and/or the responsible party.

I understand that, due to any false information, I will be subject to criminal prosecution.

Signature ____ Date____________________

Assignment of Benefits

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to **Aurora Periodontics & Implant Dentistry.**

Signature ____ Date____________________

Appointment Cancellations

If there is a need to move or cancel your appointment, we request call to inform us at least 48 hours prior to your appointment time. If you cancel or reschedule the appointment with less than a 48 hour notice a $50 charge will be applied to your account.

Signature ____ Date____________________

Photograph Consent/Release

I hereby authorize **Aurora Periodontics & Implant Dentistry** to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth. I understand that the photographs will be be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, and website publication. I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

Signature ____ Date____________________