

### About You (Patient)

Mr.       Mrs.       Ms.       Dr.

Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_

I prefer to be called \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Email \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ How Long there \_\_\_\_\_

Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Single     Married     Divorced     Widowed     Separated

### Emergency Contact

In the event of an emergency, is there a person you would like us to contact?

Name of contact \_\_\_\_\_

Relationship \_\_\_\_\_

Phone # \_\_\_\_\_ Mobile # \_\_\_\_\_

### Referral Information

How did you hear about us/Who can we thank for referring you? \_\_\_\_\_

### Dental Insurance

Name of Insurance Company \_\_\_\_\_

Group # (Plan, Local, or Policy #) \_\_\_\_\_

Insured's Name \_\_\_\_\_

Relation \_\_\_\_\_

Insured's Birth Date \_\_\_\_\_

Insured's SS# \_\_\_\_\_

Insured's Employer \_\_\_\_\_

### Office Consents

#### Please **initial** in each space

##### Consent of Care

I agree and give my consent for Integrated Dental Arts to provide dental care that is considered necessary and proper in diagnosing and treatment my dental condition. I understand that during RESTORATIVE treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination, the most common of which being root canal therapy following routine restorative procedures such as a crown. I give my permission to the dentist to make any/all changes to treatment as necessary in the interest of my oral health.

##### Cancellation Policy

It is the patient's responsibility to give Integrated Dental Arts a 48-hour notice if they will be unable to attend an appointment. Late cancellations are subject to a \$35 per hour for hygiene visits and \$50 per hour for restorative procedures. This policy makes it possible for Integrated Dental Arts to offer appointments to all patients in a timely and effective manner.

##### Deposit Policy

Because of our growing patient base and limited schedule availability, Integrated Dental Arts requires a deposit upon booking any restorative and/or deep cleaning appointment. A deposit of 25% of your estimated patient portion will be collected at time of booking. This deposit is non-refundable if you cancel within our 48-hour cancellation policy or no-show. This policy ensures Integrated Dental Arts schedule is used wisely and effectively.

##### Acknowledgement of Receipt of Privacy Practices

I acknowledge and agree that I have been informed to read the Notice of Privacy Practices Policy on Integrated Dental Arts' website. In addition, I acknowledge I can request a copy of Integrated Dental Arts Notice of Privacy Practices in writing at any time.

**DENTAL HISTORY**

Reason for Today's visit: \_\_\_\_\_  
 Date of last dental care: \_\_\_\_\_ Date of last dental X-rays: \_\_\_\_\_  
 Check (✓) if you have had problems with any of the following:

<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Loose teeth	<input type="checkbox"/> Sores or growths in your mouth
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Have you been diagnosed or think you might suffer from sleep apnea?
<input type="checkbox"/> Clicking or popping jaw/TMJ	<input type="checkbox"/> Sensitivity to (circle one): Cold Hot Sweets When biting	<input type="checkbox"/> You have a CPAP Do you use it? _____
<input type="checkbox"/> Food collection between teeth	<input type="checkbox"/> You smoke or use tobacco	<input type="checkbox"/> You snore when sleeping
<input type="checkbox"/> Have periodontal disease	<input type="checkbox"/> You vape	<input type="checkbox"/> You wear a night guard when sleeping
<input type="checkbox"/> You clench/grind your teeth	<input type="checkbox"/> You have 1 or more missing teeth that you would like replaced	<input type="checkbox"/> You don't like your smile
<input type="checkbox"/> Like to have whiter teeth		

How often do you floss? \_\_\_\_\_ | How often do you brush? \_\_\_\_\_

**MEDICAL HISTORY**

Physician's name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
 Have you ever had any serious illness or operations? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_  
 Have you ever had any blood transfusions?  Yes  No If yes, give approximate date(s): \_\_\_\_\_  
 (Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No  
 Have you or are you taking Bisphosphonates?  Yes  No  
 Check (✓) if you have or have had any of the following:

<input type="checkbox"/> AIDS/HIV+	<input type="checkbox"/> Cortisone Treatment	<input type="checkbox"/> Hepatitis A, B, C	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Acid Reflux/GERD	<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cough up Blood	<input type="checkbox"/> Herpes/Fever Blisters	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Fainting	<input type="checkbox"/> Marijuana use	<input type="checkbox"/> Swelling of Ankles
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Auto Immune Disease	<input type="checkbox"/> Headaches	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Problems: Describe: _____	<input type="checkbox"/> Psychiatric Treatment	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Blood Thinners	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Cancer		<input type="checkbox"/> Respiratory Disease	
<input type="checkbox"/> Chemical Dependency			
<input type="checkbox"/> Chemotherapy			
<input type="checkbox"/> Circulatory Problems			

**MEDICATION**

**ALLERGIES**

List the medication you are currently taking: _____ _____ _____ Pharmacy Name: _____ Phone: _____	<table border="0"> <tr> <td><input type="checkbox"/> Aspirin</td> <td><input type="checkbox"/> Penicillin</td> </tr> <tr> <td><input type="checkbox"/> Codeine</td> <td><input type="checkbox"/> Sulfa</td> </tr> <tr> <td><input type="checkbox"/> Erythromycin</td> <td><input type="checkbox"/> Tetracycline</td> </tr> <tr> <td><input type="checkbox"/> Latex</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Local Anesthetic</td> <td>_____</td> </tr> <tr> <td></td> <td>_____</td> </tr> </table>	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Latex	<input type="checkbox"/> Other _____	<input type="checkbox"/> Local Anesthetic	_____		_____
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<input type="checkbox"/> Latex	<input type="checkbox"/> Other _____												
<input type="checkbox"/> Local Anesthetic	_____												
	_____												

**SIGNATURE**

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## FINANCIAL/PAYMENT POLICY

We are committed to provide only the best dental care possible. In order to give you the best experience possible, we have found that when everyone is clear on payment for treatment, the confusion and misunderstanding is kept to a minimum. Our main concern is that you receive the proper and optimal treatment necessary to restore and maintain your dental health.

\*\*\*We ask that you realize that we do NOT work for an insurance company; rather we work 100% for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge **will always be based on your individual needs, not your insurance coverage.**

### **POLICY:**

1. Patients are expected to pay for services at the time they are rendered. Our patients who have the benefit of dental insurance are expected to pay the amount of their **estimated** co-insurance at the time of service. Payments may be made using cash, check, Visa, MasterCard, Visa, American Express and/or Discover. A returned check is subject to a returned check fee.
2. As a courtesy to our patients, we offer flexible payment options that can be discussed prior to treatment with our financial team. Options include Care Credit and Parasail personal loans.
3. Deposits will be collected upon booking any restorative and/or hygiene appointment that is lengthy in time and/or services. This ensures that our schedule is utilized in its most effective and efficient way for every patient. The deposit amount will be 25% of the estimated patient portion.
4. If for any reason patients need to cancel or reschedule their appointment, Integrated Dental Arts must be aware of this within 48 hours of the scheduled appointment time. If 48 hours notice is not given, a \$50 per hour fee will be given or the patient forfeits the paid deposit. This also ensures that the schedule is utilized wisely and effectively for every patient.
5. For any unpaid balances, you will receive 3 monthly statements. If Integrated Dental Arts needs to send out a second statement with no contact from you, a \$25 statement fee will be assessed. After 3 statements have gone unpaid, your account will be turned over to collections and you will be responsible for any legal, collection fees and court costs.

### **Things to remember as a patient with dental insurance:**

1. Dental insurance is a benefit to help cover the **basic** costs of dental treatment; most plans do not cover the true needs of the patient.
2. We offer complimentary benefit checks for patients that we complete at your initial appointment. Based on the information your dental insurance company gives us, our finance team can provide you with an **estimate** of your out of pocket cost. This estimate is never a final payment as your insurance dictates what your final payment is once services are billed.

By signing below, you are indicating that you fully understand and accept Integrated Dental Arts financial policy. For the mutual convenience of you and Integrated Dental Arts, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are also patients.

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Signature

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Date

## Integrated Dental Arts HIPAA Disclosure and Privacy Agreement

Integrated Dental respects the privacy of our patients, visitors, and staff. Ensuring that medical information is kept confidential is among our highest priorities.

To ensure that Integrated Dental is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to complete and sign this form. Integrated Dental will keep a copy of your written permission on file.

Please **CIRCLE**:

- I, **DO or DO NOT**, give Integrated Dental permission to leave detailed information on **voicemail** regarding either treatment or finances regarding my dental/medical care.
- I, **DO or DO NOT**, give Integrated Dental permission to **text** detailed messages to my Personal Cell Phone regarding either treatment or finances regarding my dental/medical care.
- I, **DO or DO NOT**, give Integrated Dental permission to email detailed information to my **email address**, regarding either treatment or finances regarding my dental/medical care.

Email Address: \_\_\_\_\_

I specifically release permission for Integrated Dental to discuss my dental conditions with the following individuals:

1. \_\_\_\_\_ Relation: \_\_\_\_\_

2. \_\_\_\_\_ Relation: \_\_\_\_\_

I am not required to sign this authorization. Integrated Dental does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. I can request a copy of this authorization be mailed to me. I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of any information and audio/video/photographic material.

I am aware that my protected health information will exist forever in either a recorded, printed, and /or electronic version or other version as may develop over time and that once it is published or disclosed in any form it will continue to be used. I understand that information about me or my child used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state law.

I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information. To do so, I must send written notice to the Integrated Dental Privacy Officer at 7251 West 20<sup>th</sup> Street, BLDG H Greeley, CO 80634. I understand that Integrated Dental, as well as other persons or entities, will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within Integrated Dental's control that have not been previously published. If not revoked/withdrawn by me, this authorization expires ten (10) years from the date that I sign it.

Patient Name: \_\_\_\_\_

(First)

(m. initial)

(last)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Integrated Dental Arts HIPAA Disclosure and Privacy Agreement

For personal representatives, please provide the following:

I, \_\_\_\_\_, represent that I am the health care agent/ guardian/ surrogate/ parent of the patient above.

Personal Representative Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\*If you are the health care agent or guardian, please provide proof of your authority to act on behalf of the patient.