HEALTH HISTORY

To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Radiation (date and area _____)
- ❑ Chemotherapy
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Stroke or blood clots
- ❑ Artificial joint or artificial heart valve
- ❑ High or low blood pressure (circle one: high or low)
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems _____
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease _____
- ❑ Alcoholism or drug addiction
- ❑ Blood transfusion
- ❑ Diabetes (circle one: taking insulin or not taking insulin)
- ❑ Neurologic condition _____
- ❑ Epilepsy, seizures, or fainting spells (last episode _____)
- ❑ Emotional condition _____
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders _____
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma (circle one: using inhaler or not using inhaler)

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics _____
- ❑ Local anesthetics _____
- ❑ Codeine or other narcotics _____
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills _____
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners) _____
- ❑ Antibiotics or sulfa drugs _____
- ❑ High blood pressure medicine _____
- ❑ Antidepressants or tranquilizers _____
- ❑ Insulin, Orinase, or other diabetes drug _____
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids _____
- ❑ Osteoporosis (bone density) or bisphosphonate medicine _____
- ❑ Other:_____
  _____
  _____

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____

DENTAL HEALTH HISTORY

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

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Blisters on lips or mouth
- ❑ Burning sensation on tongue
- ❑ Chew on one side of mouth
- ❑ Clicking or popping jaw
- ❑ Pain in jaw joints
- ❑ Sores or growths in mouth
- ❑ Sensitivity when biting
- ❑ Fear or anxiety about dental treatment

How often do you floss? _____

How often do you brush? _____

- ❑ Dry mouth
- ❑ Fingernail biting
- ❑ Food collection between teeth
- ❑ Grinding teeth or clenching
- ❑ Gums swollen or tender
- ❑ Lip or cheek biting
- ❑ Loose teeth or broken fillings
- ❑ Mouth breathing
- ❑ Mouth pain
- ❑ Orthodontic treatment, Orthodontist: _____
- ❑ Pain around ear
- ❑ Periodontal treatment
- ❑ Sensitivity (circle: Sweets, Hot, Cold)
- ❑ Have you ever been told you need to pre-medicate for dental treatment? ❑ yes ❑ no

Do you have any disease, condition, or problem not listed above?_____

Please add anything else you would like us to know about:_____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

Signature of patient (or parent) _____ Date _____

PATIENT INFORMATION

Email: _____

First Name _____ Last Name_____ MI_____ Social Security # _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Birthdate _____ ☐ Male ☐ Female ☐ Child ☐ Married ☐ Single
If college student, college name _____ ☐ P.T. ☐ F.T

Person to contact in case of emergency _____ Relationship to patient_____
Mailing Address _____ Home Phone _____
Has any member of your family ever been treated in our office? ☐ Yes ☐ No
Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to patient_____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone _____ Birthdate _____ Social Security # _____
Employer _____ Work Phone _____
Is this person currently a patient in our office? ☐ Yes ☐ No

DENTAL INSURANCE INFORMATION

Name of subscriber _____ Relationship to patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone _____
Insurance Company Name _____ Telephone Number _____
Policy / ID Number _____ Group Number _____
Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No If yes, complete the following
Name of subscriber _____ Relationship to patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone _____
Insurance Company Name _____ Telephone Number _____
Policy / ID Number _____ Group Number _____
Ins. Co. Address _____ City _____ State _____ Zip _____

FINANCIAL OBLIGATION

I acknowledge that I am liable for fees in their entirety at the time that services are rendered. If insurance is applicable, I understand that I am liable for any patient portion (coinsurance, deductible, or co-pay) at the time that services are rendered. I understand that the Dental Office will bill my insurance. If my insurance company does not pay within 60 days of my date of service, I understand that I am liable for all fees. If I do not make payment in full and/or do not fulfill the terms of my financial agreement, I understand that I will be charged an 18% finance charge. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me.

Patient (Parent/Guardian) Signature _____ Date _____

AUTHORIZATION

I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Patient (Parent/Guardian) Signature _____ Date _____

DENTAL ASSOCIATES OF THE SOUTHWEST
FINANCIAL POLICY

Co-payments, Fees and Accepted Forms of Payment

Our policy is to collect payment at the time of service. Please arrive at your appointment prepared to pay for services received or for any co-payment, co-insurance, or deductible that your insurance company requires. An estimate will be made regarding insurance coverage, but it is not a guarantee of payment.

*We accept Cash, Check, Master Card, Visa, Discover, and American Express.
*We offer financing through Care Credit Dental Fee Program (some restrictions apply).
*Returned checks will be charged a $35.00 fee in addition to any billed fees.
*Bills that are outstanding greater than 90 days will be turned over to our collection agency.
* 1.5% interest and a $5.00 statement fee will be added monthly to all past-due accounts.

Insurance Billing

As a courtesy to you, we will bill your insurance company for the cost of our services, although it is payment for all or part of the services provided, you are ultimately responsible for the full charges.

The most common reasons for insurance denial are:

1. Incorrect or outdated insurance information received from the patient. We will ask you to verify that we have current insurance information in our computer – prior to your visit. (We are happy to receive calls to update addresses and new insurance information.)
2. College students may be denied any benefits until your insurance company receives an updated class schedule for the current year.
3. We may not be listed with your insurance company. Very few dental insurance companies will not pay us, but there are some that require you to go to a preferred provider or a Dentist on their list. It is the patients' responsibility to research their dental insurance guidelines.
4. There are some procedures that may not be covered by your insurance plan. Every patient should check with their insurance before having a procedure performed by our office.
5. Most dental check-ups are covered every six months or twice in a calendar year. It is the patient's responsibility to schedule their appointments within the frame allowed.
6. Most dental plans have a contract year maximum. It is the patient's responsibility to know when that coverage amount has been met.

The above list includes only a few examples of the many ways dentists are denied payment from insurance companies.

Drs Heinicke, Wenburg, Holland and Cofman are contracted with **Delta Dental of Colorado Premier and Anthem BlueCross/Blue Shield of Colorado Plus**. Our office will gladly submit claims for non-contracted insurances, but it is the patient's responsibility to contact the insurance company to determine the non-provider benefit amount.

ACKNOWLEDGEMENT OF DENTAL TREATMENT BY NON-MEDICAID PROVIDER

I am choosing to see a non-Medicaid provider at Dental Associates of the Southwest for dental treatment. I understand and acknowledge that I am personally responsible for all fees incurred for dental treatment at said office. I agree to pay my fees in full at time of service.

By signing this agreement, you understand that we are providing healthcare services to you, and ultimately you are responsible for payment for these services.

I _____, the guarantor did read, understand, and agree with the above financial policy. I understand it is my responsibility to know what my benefits cover. If for any reason my insurance company denies payment to Dental Associates of the Southwest I am fully responsible for the charges.

Signature: _____ Date: _____

Dental Associates
Of the Southwest

801 Florida Road # 2
Durango, CO 81301
970-259-0113
www.dentalassociatessw.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective October 1, 2018

This Notice of Privacy Practices applies to the following organizations.

Information may be shared between both of Dental Associate of the Southwest offices:

Durango Office:
801 Florida Road # 2
Durango, CO 81301

Bayfield Office:
1405 Kremer Drive
Bayfield, CO 81122

For more information, please contact our dental office manager:
Phone: 970-259-0113 Email: info@dentalassociatessw.com

NAME OF PRACTICE_____

Acknowledgement of Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledgement of receipt of same. *You may refuse to sign this acknowledgement form.*

By signing this form I confirm that I have received a copy of the office Notice of Privacy Practices.

Print name _____

Sign name _____

Date _____

Written acknowledgement was not obtained.

0 Patient refused to sign

0 Emergency situation

0 Unable to communicate with patient

0 Other _____

_____

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