ASPEN HEIGHTS DENTAL PATIENT INFORMATION

Welcome to our office! 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 _____ Birthdate _____

☐ Male ☐ Female **(If minor, responsible party)** _____

Home Phone _____ Cell Phone _____ Social Security Number _____

Mailing Address _____ City _____ State _____ Zip _____

Email Address _____ Preferred Method of Contact: ☐ CALL ☐ EMAIL ☐ TEXT

Emergency Contact _____ Emergency Phone _____

☐ Child ☐ Married ☐ Single ☐ Divorced ☐ Widowed (If married) Spouses Name _____

How Did You Hear About Our Office? _____

BILLING AND INSURANCE INFORMATION: ☐ **Not Covered by Dental Insurance**

Dental Insurance Co. _____ ID Number _____ Group Number _____

Policy Holder _____ Policy Holder Birthdate _____ Relationship _____

Secondary Insurance? ☐ YES ☐ NO

Secondary Insurance Co. _____ ID Number _____ Group Number _____

Policy Holder _____ Policy Holder Birthdate _____ Relationship _____

MEDICAL HEALTH HISTORY

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

- ☐ Abnormal Bleeding (after extractions, surgery, or trauma)
- ☐ AIDS or HIV Positive
- ☐ Alcoholism
- ☐ Allergies or Hives
- ☐ Anemia or Blood Disorders
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Artificial Valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Emotional Condition
- ☐ Epilepsy, Seizures, or Fainting Spells
- ☐ Heart Ailment or Angina
- ☐ Heart Murmur, Mitral Valve Prolapse, Heart Defect
- ☐ Hepatitis or other Liver Disease
- ☐ High or Low Blood Pressure
- ☐ Kidney Disease
- ☐ Migraine headaches or frequent headaches
- ☐ Neurologic Condition
- ☐ Pacemaker
- ☐ Rheumatic Fever or Rheumatic Heart Disease
- ☐ Sinus Trouble
- ☐ Tuberculosis or other Lung Problems

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

- ☐ Aspirin
- ☐ Barbiturates, Sedatives, or Sleeping Pills
- ☐ Codeine or Other Narcotics
- ☐ Latex Materials
- ☐ Local Anesthetics (novocaine)
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Other: _____

Are you taking any of the following?

- ☐ Antibiotics
- ☐ Anticoagulants (blood thinners)
- ☐ Antidepressants
- ☐ Aspirin
- ☐ Bisphosphonate
- ☐ Cortisone or other steroids
- ☐ High blood pressure medicine
- ☐ Insulin, Orinase, or other Diabetes Drug
- ☐ Nitroglycerin
- ☐ Other: _____
- ☐ Taking Hormones
- ☐ Taking Birth Control
- ☐ May be Pregnant/Expected Delivery Date _____
- ☐ Do You Smoke or Use Tobacco? ☐ YES ☐ NO
- ☐ Are You Required to Pre-Medicate? ☐ YES ☐ NO

Name of your physician _____

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

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

Signature of Patient **(or legal guardian)** _____ Date _____

ASPEN HEIGHTS DENTAL FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

Patients must complete our Information and Health History form before seeing the doctor.

PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, VISA, MASTERCARD and DISCOVER.
We can extend payments thru
Care Credit.

TERMS: Net due the date of the service unless otherwise agreed to in writing. An interest charge of 1.9 % per month (annual percentage rate 22.8%) of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 33.3 % collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs. If my account is turned over for collections, I understand that the patient/doctor agreement has been violated and Dr. Dorny and/or Dr. Richins will be under no obligation to continue to treat me or any of my dependents.

Regarding Insurance

We accept the assignment of most insurance plans. If you are having your teeth checked and cleaned, many plans pay 100% of the charges. However, if you are receiving care for teeth which need to be restored or extracted, your deductible and patient portion is to be paid at the time of your visit. We will then bill your insurance company. **The balance of your account, however, is your responsibility whether your insurance company pays or not.** We cannot bill your insurance company unless you give us your complete insurance information, sign the agreement at the bottom of the page, and if so, required by your plan, provide us with a completed insurance form provided by your human resources office. In any event, please realize that the insurance policy is a contract between you and your insurance company. WE ARE NOT A PARTY TO THAT CONTRACT. **We accept assignment as a courtesy to you.** If your insurance company has not paid your account in full within 30 days of billing for the services, the balance will automatically be transferred to your Credit Card. In the event you are paying your balance by credit card, if you sign the credit card authorization at the bottom of this form, we will be happy to automatically bill the balance to your Visa or MasterCard.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge within the range of what is usual and customary for our area. You are responsible for payment regardless of any insurance company's plan allowances.

Minor Patients

The adult who brings a minor child in and the parents (or guardians of the child) are responsible for full payment. We will bill an absent parent only once. In the event the absent parent is unwilling to pay after the first billing, the accompanying parent will be held responsible for the bill IN FULL. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangements have been verified.

Missed Appointments

When you reserve time, it becomes unavailable to another patient. If you don't keep your appointment you have inconvenienced another patient who needed that time. We would appreciate at least 24 hours' notice so that we can contact others who wanted that time. It is our policy to charge for late cancellations to encourage people to be considerate of others. This charge is based on the length of appointment and the charge is $10.00 per 10-minute appointment. Please help us to serve you and our other patients better by keeping your scheduled appointments.

Insurance

It is sometimes necessary to obtain pre-authorization before services are begun. We can provide you an estimate of your expenses for treatment. Your insurance may not allow the full or even partial payment. Because insurance plans and payments vary widely, we consider the patients responsible for the account. Any payment made to us by your insurance company will be credited against your balance or returned to you if the account is paid in full.

Release and Assignment

I hereby authorize Dr. Richins and Dr. Dorny and/or their associates to release to my insurance company or its representatives any information, including the diagnosis or record of any treatment or examination rendered to me during the period of such dental care. I also authorize and request my insurance company to pay directly to the above same doctor, the amount due according to my policy agreement

X_____Date: _____

Signature of Responsible Party, Insured or Spouse

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment. I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva, or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I authorize Dr. Christopher Dorny, DMD and Dr. Brett Richins,DMD or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is possible for the tongue, cheek, or other oral tissues to be inadvertently lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name (Printed): _____

Signature: _____ Date _____
(Patient, legal guardian or authorized agent of patient)

Witness: _____ Date _____

Aspen Heights Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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