Colorado Premier Dental

Complete Family, Cosmetic
& Oral Rehabilitative Dentistry

PLEASE COMPLETE THE FOLLOWING INFORMATION:

PATIENT INFORMATION (CONFIDENTIAL)

Name: Birthdate:
Email: SSN:
Home phone: Cell phone:
Address: City: Zip:

Check one: Minor Single Married Divorced Widow

Name of Employer:
Address:
City: Zip: Phone:

Referred by

INSURANCE INFORMATION:

Name of insured: Relationship to patient:
Insured SSN: Birthdate:
Insurance company:
Address:
Group #: Policy/ID #: Phone #:

Additional Insurance Information:

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. All the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Colorado Premier Dental / Dr. Huyen Le DDS and Dr. Chun Guo DMD to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to Colorado Premier Dental / Dr. Huyen Le DDS and Dr. Chun Guo DMD or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services based off what my insurance plan covers. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or guardian of minor) Date

Please turn over to complete past medical history

DATE:

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If Yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Patient Name: _____ Date: _____

Broken or cancelled appointments

Your appointment time is valuable and has been reserved specifically for you. If you need to cancel an appointment, please notify us at least 48 hours in advance. For Monday appointments, you must notify us the Thursday before. We charge $75.00 for each canceled or broken appointment if you do not give us the required advance notice. Please notify us if an emergency makes it impossible for you to give us 48 hours' notice so we can discuss this with you. If you arrive 15 minutes or more late to your appointment, you will likely be asked to reschedule unless the dentist's schedule can still accommodate you.

Insurance and Financial Agreement

Our practice is in-network for most dental insurance carriers, and we are a PPO provider. Please provide your insurance card on your first visit and let us know of changes in coverage or carrier on subsequent visits. As a courtesy, our office files all necessary paperwork with your insurance company. Our friendly staff will be happy to help you maximize your dental benefits. Many dental insurance policies have exclusions and limitations that can affect your out-of-pocket cost. At the ⍰me of service, you will need to pay the expected estimated insurance deductible and any estimated amount that we expect your insurance will not cover. Remember that many procedures may not be fully covered. In those instances, you are responsible for the remaining amount. However, please remember that your dental insurance policy is a contract between you, your employer and the insurance company. Please keep in mind that you are responsible for the total amount should your insurance benefits result in less coverage than anticipated. Before proceeding with treatment, we will provide a written estimate of fees. We try to get accurate information about insurance benefits and coverage before treatment. However, we cannot be sure what the insurance company will pay, if anything, until the claim is submitted and the insurance company actually pays on the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important because you are responsible for all treatment charged whether your insurance company provides any benefits. Also, some companies take care of claims promptly while others delay payment for several months. After 60 days from the treatment date, if payment is not received from your insurance, the payment will be due in full from you and the insurance company will be reimbursing you. Please understand that we cannot accept responsibility for collecting your insurance claim or for negotiating disputed claims between you and your insurance company.

We want you to feel comfortable and confident in all aspects of our practice. Remember we do not treat according to your insurance, we treat you as an individual, care about your dental health, and dedicated to providing the best treatment available to our patients. Please be aware that full payment is due at the ⍰me of service for the Initial Emergency, Limited appointments or New Patient appointments that are scheduled on the same day of your visit.

I have read, understand and agree to the above financial agreement. Any questions and concerns were answered fully to my satisfaction. I understand that I am responsible for all fees and/or balances due and agree to pay them in a timely manner in order to avoid any additional charges. I, the undersigned (patient or legally responsible party) hereby assume all financial responsibilities for treatment rendered. Furthermore, I authorize release of any information relating to my insurance claims and the assignment of any and all dental benefits paid directly to Colorado Premier Dental PLLC. I understand that I am responsible for all costs of dental treatment and any additional costs incurred in collecting this account, including interests, court costs and attorney fees, which may be added to my balance. I agree to the above policies and

_____

Patient or Guardian Signature

PATIENT CONSENT FORM
(HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most recent copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____