Welcome!

We are pleased to welcome you to our practice. Please take a few moments to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information:

Today's Date: _____

Patient Name: _____ Social Security: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Number: _____ Cell Phone Number: _____

Work Number: _____ E-mail Address: _____

Can we use your e-mail and cell phone for electronic correspondence?
E-mail: Yes _____ No _____ Text Messages: Yes _____ No _____

Sex: Male Female Date of Birth: _____ Age: _____ Married: _____ Divorced: _____ Single: _____

Employer/School _____ Occupation _____

Employer/School Phone: _____ Whom may we thank for referring you? _____

Emergency Contact: _____ Phone: _____ Relationship to patient: _____

Primary Insurance:

Person Responsible for Account _____ Social Security: _____

Relationship to patient: _____ Date of Birth: _____

Address (If different from patient's): _____

City: _____ State: _____ Zip: _____

Person Responsible Employed by: _____ Occupation: _____

Insurance Company: _____ Insurance Co Phone Number: _____

Insurance Company Address: _____

Plan Group #: _____ Subscriber ID (If different than social): _____

Names of other dependants covered under this plan: _____

Additional Insurance:

Is patient covered by additional insurance? Yes: _____ No: _____

Subscriber Name: _____ Social Security: _____

Relationship to patient: _____ Date of Birth: _____

Address (If different from patient's): _____

City: _____ State: _____ Zip: _____

Person Responsible Employed by: _____ Occupation: _____

Insurance Company: _____ Insurance Co Phone Number: _____

Insurance Company Address: _____

Plan Group #: _____ Subscriber ID (If different than social): _____

Names of other dependants covered under this plan: _____

Dental History

Patients Name: _____

Reason for Today's Visit: _____ Date of Last Dental Care: _____

Former Dentist: _____ Date of Last Dental X-Rays: _____

Check if you have had a history with any of the following:

_Bad Breath
_Bleeding Gums
_Clicking or popping jaw
_Dry Mouth
_Grinding Teeth
_Loose teeth
_Food collection between teeth
_Broken fillings and/or crowns
_Sores or growths in the mouth
_Periodontal Treatment
_Sensitivity to cold/hot/sweets (circle)

How often do you floss? _____ How often do you brush? _____

Do you have any missing teeth? _____ Are you interested in permanent replacements? _____

Are you unhappy with the appearance of your teeth? _____

Is there anything you would like to change about your smile? _____

Medical History

Physicians Name: _____ Date of last visit: _____

Have you had any serious illnesses or operations? _Yes _No If yes, please describe: _____
Have you ever had a blood transfusion? _Yes _No If yes, give approximate dates _____
(Women) Are you pregnant or nursing? _Yes _No Taking birth control pills? _Yes _No

Check if you have had any of the following:

_Anemia
_Arthritis/Rheumatism
_Artificial Heart Valves
_Artificial Joints
_Asthma
_Back Problems
_Blood Disease
_Cancer
_Chemical Dependency
_Chemotherapy
_Circulatory Problems
_Cortisone Treatments
_Cough, Persistent
_Cough up blood
_Diabetes
_Epilepsy
_Fainting
_Glaucoma
_Headaches
_Heart Murmur
_Heart Attack/Angina
_Hemophilia
_Hepatitis
_High Blood Pressure
_HIV/AIDS
_Jaw Pain
_Kidney Disease
_Liver Disease
_Mitral Valve Prolapse
_Pacemaker
_Radiation Treatment
_Respiratory Disease
_Rheumatic Fever
_Scarlet Fever
_Short breath
_Skin Rash
_Stroke
_Swelling of Joints
_Thyroid Problems
_Tobacco Habit
_Tonsilitis
_Tuberculosis
_Ulcer
_Venereal Disease

Please list any medications you are currently taking: _____

Have you ever taken any of the group of drugs collectively known as "fen-phen?" (Ionimin, Adipex, Fastin, Pedimin, and Redux)? _Yes _No

Have you ever taken any of the group of drugs collectively known as Bisphosphonates (Fosomax, Boniva, Actonel, etc)? _Yes _No
If "Yes", were they taken by or an oral route or an intravenous route?

Are you allergic to any of the following:
_Penicillin _Aspirin _Iodine _Sulfa _Metals _Latex _Other (please list): _____

Have you ever had an adverse reaction to local anesthetic? _Yes _No If yes, please describe: _____

_____ _____
Signature of patient, parent, guardian, or personal representative Date

_____ _____
Please print name Relationship to patient

_____ _____
Dr. Signature Date

Blood Pressure _____ Pulse _____ ASA I II III IV

The Dental Shoppe

www.dentalshoppe.com
297 North Hwy.287 | Ste. 104 • Lafayette, CO 80026
www.dentalshoppe.com
(303)665-8321

Financial Agreement

Patient Name: _____ (Last) _____ (First) ____ (MI)

_____
Preferred Name

This agreement is to inform you of your financial obligation to our practice. We care committed to providing you with the most comprehensive dental care.

All charged you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provide, OUR RELATIONSHIP IS WITH YOU, OUR PATIENT. NOT WITH YOUR INSURANCE COMPANY. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a part to that agreement. If payment from your insurance company is not received within 60 days for date of service, you will be expected to pay the balance in full. As a courtesy to you we will help you process you insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of benefits.

Your estimated copayment for treatment, which is the amount not covered by insurance, is due at the time that treatment is provided. Your estimated copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. All estimates for the dental care can only be extended for a period of three months from the date of your examination.

I understand that responsibility for payment for dental services in this office for myself and my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 18% and court cost.

I understand that any unpaid balance after 90 days will be assessed annual interest at the rate of 18%(1.5% monthly). Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully inderstand that I am responsible for payment of fees not covered by insurance. I authorize the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after havng a full explaation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy right as provided by the Healthcare Information Portablilit and Accountablility Act 1996. I hereby authorize this provider and its employees, agents and assignees to contact me via email, text message.

Our practice accepts cash, peronal checks, all major credit cards. Third party financing is available upon request and approval with Cared Credit. A $20.00 fee and collection costs will be assessed for all returned checks.

As a courtesy to our office and other patients who are waiting for an appointment, we request 24 hours notice if you need to reschedule an appointment. For all appointments we will call three days in advance to verify your reserved appointment. We do request that you call back to confirm your appointment. All missed appointment we do charge a $75.00 missed appointment fee per hour.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Signature of guarantor of payment/responsible party:

Signature _____

Date

Relationship to Patient:

_____

_____

_____

Response Date: _____

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Assignment of Benefits

Patient Name: _____ (Last) _____ (First) ___ (MI)

_____
Preferred Name

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand this agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

Although we are willing to complete insurance information forms and submit claims on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.

We required you to pay the estimated copayment, which is the amount not covered by your insurance company, at the time we provide service to you. The copayment is only an estimate of charged and may be found to be insufficient after review by your insurance company.

Insurance payments ordinarily are received within 30-60 days from the time billing. If your insurance company has not made payments to our practice within 60 days, we ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

Our practice DOES NOT GUARANTEE that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

Our Practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation that your insurance company requests to sort our any confusion or questions that may arise. We will cooperate fully with the regulations and requests for your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by you insurance company to our practice.

☐ ***By checking this box you agree to the terms and conditions of the Assignment of Benefits.**

Signature of guarantor of payment/responsible party:

Signature _____

Date

Relationship to Patient:

_____

_____

_____

Response Date: _____

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Consent for Servies and HIPAA

Patient Name: _____ (Last) _____ (First) ____ (MI)

_____
Preferred Name

I grant my permission to The Dental Shoppe to upload and store confidential patient information to the secured website for the dental practice.

I also understand that Sate and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable to may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure,maintenance and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with th operation of such services, and is acting on my behalf in uploading my patient information. I understand that the dental practice will is commercially reasonable efforts to maintain the confidentiality of all patient information.

I give permission for The Dental Shoppe to disclose information relating to my dental records, dental insurance, treatment, payments/billing questions, and scheduling to the following individual(s):

_____

_____

Relationship to Patient:

_____

_____

Signature _____

Date _____

Response Date: _____

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Confirmation Policy

Patient Name: _____ (Last) _____ (First) ____ (MI)

_____
Preferred Name

Here at The Dental Shoppe we make every effort to maintain an efficient and effective schedule. We pride ourselves with being on time and prepared for your scheduled appointment. When you schedule an appointment, we reserve that time just for you with our dental staff and doctor. We are committed to honoring the appointment time of our scheduled patients, so it is critical that you confirm your appointment 24 hours of your appointment time and that you arrive no later than15 minutes of the scheduled time. If you arrive 15 mintues after your scheduled apppointment, our team may not have enough time to complete what is schedule or we may ask you to reschedule.

Here is how the process works:

Appointment Reminders:

Email or text messages are sent to you the day you book your reserved appointment. You can add this directly to your phone calendar.
You can reply to any email or text message to contact the office.
Please make sure you have confirmed your appointment prior to this final text message. (Read below)

Confirming your reserved appointment:

To ensure that you keep this reserved appointment, you need to confirm through email, text message, or phone.
Our automated system will start this process1 week prior to your reserved appointment time and you have to simply reply to us that you can still make it.
We will try and contact you 3 days prior to your reserved appointment and every day after though email, text and finally phone until appointment is confirmed.
We will attempt 1 last time 24 hours before your reserved appointment time asking you to confirm by a specific time. If we do not hear from you by that time, we will release that reserved appointment time to other patient and will reschedule you.

Any missed or no show appointment will be charged a $75.00 fee for a cancellation fee. This can not be billed to your insurance company.

☐ ***By checking this box, I acknowledge that I have read this statement.**

Signature _____

Date _____

Response Date: _____

COVID-19 PANDEMIC - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system. By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Name Date

_____

Signature

_____

Witness

Temperature (degrees Fahrenheit) reading at time of appointment:

COVID-19 PANDEMIC DENTAL TREATMENT

NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

Pursuant to statements from the Center for Disease Control (CDC), the American Dental Association (ADA), and the State of Colorado governor's office, non-essential or elective treatment, based on the assessment of our staff, can be performed on or after May 1, 2020. I understand that visiting The Dental Shoppe for routine dental care increases my risk of contracting the Covid-19 virus, and I accept responsibility for any testing or treatment that may arise from a positive Covid-19 diagnosis.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

Lastly, I agree to notify The Dental Shoppe as soon as possible if I were to test positive for the Covid-19 virus within two weeks of my dental visit.

I have read and understand the information stated above:

_____ _____

Name Date

_____

Signature

_____

Witness