Summit Smiles Dental
6240 S. Main St, Suite 260
Aurora, CO 80016
(303) 627-5432
info@summitsmilesdental.com

Welcome to our office, and thank you for selecting us to help with your dental care. We look forward to meeting you at your upcoming appointment.

Please download and print all of the new patient forms. Please complete them at your convenience and bring them to your appointment. If your employer provides dental insurance, please bring your card with you as well as a list of any prescriptions that you take regularly. If time allows please fax or email back the forms to our office, this will allow us to verify your insurance benefits.

On your first visit with us we will listen carefully to your dental concerns and attempt to answer all of your questions thoroughly. Our intent is to get to know you and your dental health needs. At your appointment you can expect:

- A comprehensive examination and review of your oral health
- A thorough evaluation and charting of your dental status
- Take full mouth series of x-rays
- Take intra-oral facial images and show you a photo tour of your mouth
- Treatment plan of needed restorations if any
- Cleaning of your teeth, if gums and tissue are healthy

You will find our doctors and team to be very friendly, understanding and gentle. We provide our patients exceptional dental treatment in a comfortable and safe environment.

Please arrive 20 minutes early for your first visit so we can review your information with you. We look forward to seeing you and your family very soon.

Thank You,

The Team at Summit Smiles Dental

Patient Information

Name: Gender: □ F □ M

Birth date: Soc. Sec. #:

Address: City/ State/Zip:

Home Phone#: Cell Phone #:

Employer: Work Phone #

Emergency Contact Name & Phone #

Email Address:

Referral Source - Who May We Thank For Referring You?

Person Responsible For Account (if different from patient)

Name: Gender: □ F □ M

Birth date: Soc. Sec. #:

Address: City/State/Zip:

Home Phone#: Cell Phone #:

Relationship to patient:

Dental Insurance Information

Primary

Ins. Co: Phone:

Billing Address/State/Zip:

Subscriber: Subscriber ID#: Group#:

Gender: □ F □ M Birth date: Soc Sec #:

Secondary

Ins. Co: Phone:

Billing Address/State/Zip:

Subscriber: Subscriber ID#: Group#:

Gender: □ F □ M Birth date: Soc Sec #:

Assignment & Release

I agree to assign directly to Summit Smiles Dental all insurance benefits, if any, payable to me for service rendered. I understand that I am financially responsible for all charges not covered by my insurance carrier.

_____ _____

Patient or Guardian Signature Date

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

- **Payment is due at time of service**
- **We accept Cash, Checks, MasterCard, Visa, Discover**
- **Care Credit Financial payment plans are available (6, &12 Mo Interest free options, or extended terms with interest)**

ADULT PATIENTS AND MINORS ACCOMPANIED BY ADULT

Adult patients and adults accompanying a minor patient are responsible for payment at the time of service. Special financial arrangements can be made with the business office before treatment begins.

UNACCOMPANIED MINORS

Proposed treatment sometimes changes during the procedure due to the needs of the patient. To assure quality care of the patient, it may be necessary to proceed without the consent of the parent or the guardian if they have left the facility. The parent or guardian is responsible for payment the day of treatment, and will be financially responsible for the necessary changes or additions to the minor's treatment.

INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER, AND YOUR INSURANCE COMPANY.

As a courtesy to our patients we will file your insurance claims and accept payment from your insurance company. We will be glad to assist you as much as we can with your insurance and to help you to receive the most benefits possible. ***We do request payment of any treatment or percentage of treatment estimated to not be covered by insurance at the time of service.***

We can submit to most insurance companies, as long as your plan allows you to come to the dentists in this practice. If you do not have your current insurance information or if insurance verification is not possible, full payment at time of service is requested. When insurance information is received and entered after your appointment, we will complete the claim forms so that the insurance company will promptly reimburse you.

We will submit claims for you and will accept 3rd party payments from insurance company. We will assist you in receiving the maximum insurance benefits available for your procedure. If your insurance company has not paid their portion within 45 days, the full balance will be your responsibility. You will have an additional 15 days to pay the balance.

RESCHEDULED OR MISSED APPOINTMENTS

We request the courtesy of 2 business days notice should you need to reschedule or cancel your appointment. Missed appointments without 2-business days notice are billed at $100.00 per hour of the appointed time. Please help us serve you better by keeping scheduled appointments.

LATE ACCOUNTS

Balances due for 60 days will be considered delinquent. We reserve the right to forward accounts which are delinquent to an independent service for collection.

Signature_____ Date _____

Health History

Dr.'s Initials _____

PATIENT

► **Patient Name:** _____ Emergency Contact Name & Phone#: _____

HEALTH HISTORY

► **Physician's Name:** _____ Date of last visit: _____

► **Have you been diagnosed with or are you currently experiencing the following conditions?**

Acid reflux	☐ Y	☐ N	Headaches, chronic, migraine	☐ Y	☐ N	Sleep apnea	☐ Y	☐ N
AIDS/HIV	☐ Y	☐ N	Heart murmur	☐ Y	☐ N	Snoring	☐ Y	☐ N
Anemia	☐ Y	☐ N	Heart problems	☐ Y	☐ N	Stroke	☐ Y	☐ N
Arthritis, Rheumatism	☐ Y	☐ N	Hepatitis, Type _____	☐ Y	☐ N	Thyroid problems	☐ Y	☐ N
Artificial heart valves, yr_____	☐ Y	☐ N	Herpes – Cold sores	☐ Y	☐ N	TMJ, Jaw pain	☐ Y	☐ N
Artificial joints, yr_____	☐ Y	☐ N	High blood pressure	☐ Y	☐ N	Tonsillitis, recently	☐ Y	☐ N
Asthma	☐ Y	☐ N	Kidney disease	☐ Y	☐ N	Tuberculosis	☐ Y	☐ N
Bleeds abnormally	☐ Y	☐ N	Liver disease	☐ Y	☐ N	Tumor or growth on head or neck	☐ Y	☐ N
Blood disease	☐ Y	☐ N	Low blood pressure	☐ Y	☐ N	Ulcer	☐ Y	☐ N
Bone Density Medication	☐ Y	☐ N	Mitral valve prolapse	☐ Y	☐ N	Venereal disease	☐ Y	☐ N
Cancer, Type_____	☐ Y	☐ N	Mouth breather	☐ Y	☐ N	Difficult having mouth open?	☐ Y	☐ N
Chemotherapy	☐ Y	☐ N	Nervous, anxiety problems	☐ Y	☐ N	Difficult lying back in dental chair?	☐ Y	☐ N
Congenital heart lesions	☐ Y	☐ N	Pacemaker	☐ Y	☐ N	Do you have an excessive dry mouth?	☐ Y	☐ N
Cortisone treatments	☐ Y	☐ N	Recent psychiatric care	☐ Y	☐ N	Are you taking blood thinners?	☐ Y	☐ N
Current tobacco use, smoking	☐ Y	☐ N	Radiation treatment	☐ Y	☐ N	Major surgery? _____	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Respiratory disease	☐ Y	☐ N	Hospitalized for? _____	☐ Y	☐ N
Epilepsy	☐ Y	☐ N	Shortness of breath	☐ Y	☐ N			
Glaucoma	☐ Y	☐ N	Sinus trouble, chronic	☐ Y	☐ N	Do you take any non-prescribed drugs?	☐ Y	☐ N
						If yes, what and how often? _____		

► **Do you have any other dental or medical condition(s) that could affect your dental treatment?** If so, please describe below:

_____

_____

WOMEN ONLY Pregnant? Due date_____ ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N Are you nursing? ☐ Y ☐ N

Blood Pressure: _____

► **List <u>all</u> medications you are currently taking and the correlating diagnosis:**

Med:_____ Dose:_____ Frequency:_____ For:_____

Med:_____ Dose:_____ Frequency:_____ For:_____

Med:_____ Dose:_____ Frequency:_____ For:_____

Med:_____ Dose:_____ Frequency:_____ For:_____

Pharmacy name:_____ Phone (_____) _____

► **Indicate <u>all</u> of your allergies below:**

☐ Aspirin	☐ Iodine	☐ Penicillin
☐ Barbiturates	☐ Latex	☐ Sulfa
☐ Codeine	☐ Local Anesthetic	☐ Tetracycline
☐ Epinephrine		☐ None

ACKNOWLEDGEMENT

► **Check the acknowledgement with your signature below:**

☐ I attest that the dental and medical information above is current, complete, true, and accurate. I accept full responsibility for any information not updated or shared with the doctor.

Patient (or Guardian) Signature: _____ **Date:** _____/_____/_____

Name (if signing for minor): _____

GENERAL CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, may have some inherent risks.

These risks are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction**. Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (paresthesia)**. Local anesthetic, or its administration, while almost always adequate to allow comfortable

   care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness**. Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding.**
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines, which most often lead to clinical success, there are occasional cases, as in any medical treatment, that do not turn out as planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

THANK YOU FOR READING THE GENERAL CONSENT AND OUR FINANCIAL POLICY. LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS:

_____ _____

Patient's signature **Date**

_____ _____

Parent's signature (if minor patient) **Date**

Patient Introduction to Laser Bacterial Reduction
Consent for Laser Bacterial Reduction

We are constantly learning and striving to advance the standard of patient care in our office. As such we have recently added a new procedure to your routine cleaning care to help fight periodontal disease.

Periodontal disease affects approximately 80% of adults and is a growing epidemic in our society. Understanding of this disease has increased greatly over the last few years. We now know that Periodontal Disease is a bacterial infection in the pockets around teeth. As such, we **now** not only treat Perio with removal of mechanical irritants and diseased tissue (your normal cleaning) but are also addressing the underlying infection that causes it. With that thought in mind we recommend that all of our patients have their teeth decontaminated prior to cleaning appointments for three major reasons.

1. **To reduce or eliminate bacteremias.** During the normal cleaning process most patients will have some areas that may bleed, this allows bacteria that are present in all of our mouths to flood into the bloodstream and sometimes settle in weakened areas of our body such as a damaged heart valve or artificial knee or hip etc. We pre-medicate those patients that we know have a heart condition or artificial joints with antibiotics so that these bacteria can't cause harm to these areas. Latest research shows that these oral pathogens have now been linked to a number of other diseases such as cardiovascular disease, rheumatoid arthritis, low birth weight babies, diabetes etc. Needless to say anything that we can do to reduce or eliminate these bacteremias is a positive for our patients.

2. **To prevent cross contamination** of infections in one area of your mouth to other areas. Decontamination minimizes the chance that we may inadvertently pick up bacterial infection in one area of your mouth and move it to others.

3. **To kill periodontal disease bacteria** and stop their infections before they cause physical destruction or loss of attachment around your teeth.

The laser decontamination process is painless and normally takes about 5-10 minutes. We **highly** recommend that you take advantage of this service as part of your routine cleaning.

Laser decontamination is $30 and is NOT covered by insurance. Unfortunately insurance coverage is almost always behind the leading edge in high tech health care.

Please ask your hygienist if you have any questions regarding this treatment. Please sign below to consent for us to perform this service for you today and at your future recare appointments.

Signature:_____ Date: _____

New Patient Questionnaire

Patient Name: _____

Please take a moment to write down what you wish to achieve during your visit today and future visits. We want to know what your main concern is so that we can be sure to address it with you.

_____

_____

We know people sometimes wish their teeth or smile were different. Is there anything you would like to discuss about your smile or teeth?

_____

_____

Do you have any sensitive teeth or areas in your mouth?	Yes	No
Are you happy with your bite?	Yes	No
Is your bite comfortable?	Yes	No
Have you ever had TM (Jaw) joint problems?	Yes	No
Do your jaws click or pop?	Yes	No
Have you had braces in the past?	Yes	No
Do you wear a retainer now?	Yes	No
Have you ever been told you have (periodontal) gum disease?	Yes	No
Do you have any cosmetic bonding on your teeth?	Yes	No
Do you wear a night guard for grinding or clenching?	Yes	No
Does the appearance of the silver fillings bother you?	Yes	No
Are you happy with the size and shape of your teeth?	Yes	No
Would you like your teeth to be whiter?	Yes	No

Consent for Use and Disclosure of Health Information

Patient Giving Consent:_____

Please read the following statements carefully:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

I also give consent for my treatment and financial arrangements to be discussed with _____

_____

Signature:_____ **Date:**_____

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, by contacting:

Jennifer Tucker
C/O Practice HIPAA Compliance Officer
6240 S. Main St, Ste 260
Aurora, CO 80016

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent. By signing below you acknowledge you have had a full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. You also consent to our use and disclosure of protected health information to carry out treatment, payment activities and heath care operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Representative's Name:_____ Relationship to Patient: _____

REVOCATION OF CONSENT (Do Not Sign This Portion Unless You Are Revoking Your Consent)

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and health care operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____ Date: _____

You are entitled to a copy of this consent after you sign it.

Practice Appointment Guidelines

Our practice is dedicated to quality care and exceptional services.

We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of our patients. In return, we ask that all patients make every effort to arrive on time and not make changes to their reserved dental appointments.

Arriving late for an appointment creates problems for our dentists, hygienists and their next patient's appointments. Broken or missed appointments create scheduling problems for everyone. If you must make a change to a reserved dental appointment we require 48-hour notice so that we may contact and accommodate the needs of another patient. A charge of $100.00 an hour will be applied for broken and missed appointments without the 48-hour notification.

When a patient arrives 15 or more minutes late for a reserved dental appointment it will be considered a missed appointment. Our dental team cannot be asked to sacrifice the quality of your treatment by trying to complete it in less than the required amount of time.

The missed appointment charge of $100.00 an hour will apply for late arrivals of 15 or more minutes. Arriving 15 or more minutes late for your appointment will require that the appointment be rescheduled.

Thank you for your cooperation in this manner.

Date: _____

Patient Signature: _____

Patient Representative: _____

Office Representative: _____

Thank you for completing your paperwork. We would love to receive your paperwork back from you soon so we can begin entering your information into your patient file.

If you have records you need for us to request from a previous dental practice and receive before your appointment please complete a Release of Records form and forward to your previous dental office. This can be found in the website in the patient forms section, consents and waivers.

If you have insurance and we get your information prior to your appointment we can research how your insurance plan works and be able to answer questions regarding your benefits and any treatment that you may need.

Please return these forms to us by mail, fax or by email, whichever is easier for you.

Our contact numbers are:

- Phone – 303-627-5432
- Fax – 720-862-2119
- Email – info@summitsmilesdental.com

We look forward to meeting you very soon.

The Doctor and Team at
Summit Smiles Dental