

# Welcome

*Thank you for trusting us with your dental care.  
We promise to do our best to provide you with  
the finest care available. If you have any  
questions please do not hesitate to call us.*

Patient # \_\_\_\_\_

SS # \_\_\_\_\_

Date \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for \_\_\_\_\_ years

E-mail \_\_\_\_\_ Cell Phone #1 (\_\_\_\_) \_\_\_\_\_ Cell Phone #2 (\_\_\_\_) \_\_\_\_\_

Employer/School \_\_\_\_\_ Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Employer/School Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## RESPONSIBLE PARTY

Name of Person Responsible for this Account \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Bank \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Currently a patient in our office? ☐ Yes ☐ No E-mail \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

## INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

## ADDITIONAL INSURANCE

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

- O V E R -



## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_  
Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_  
Address \_\_\_\_\_

Check (✓) if you have had problems with any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                        | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding gums                     | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw           | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between the teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism         | <input type="checkbox"/> Cortisone Treatments     | <input type="checkbox"/> Hernia Repair         | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves       | <input type="checkbox"/> Cough, Persistent        | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/> Cough up Blood           | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems                 | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Bleeding Abnormally           | <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Blood Disease                 | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemical Dependency           | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Chemotherapy                  | <input type="checkbox"/> Heart Problems           | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Circulatory Problems          | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Rheumatic Fever       |   |

List medications you are currently taking and the correlating diagnosis:

Allergies:

## AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

**Payment is due in full at time of treatment unless prior arrangements have been approved.**

## RELEASE OF DENTAL RECORDS

Shores Family Dentistry  
John D. Siegmund, D.D.S.,P.C.  
Jonathan M. Anderson, D.D.S.,P.C.  
Stephen M. Creal, D.D.S.  
4360 Boardwalk Drive Suite 100  
Ft. Collins, Co 80525  
(970)226-2920  
(970)226-8699 FAX

Email: frontdesk@shoresfamilydentistry.com

I, \_\_\_\_\_, am requesting a copy of my current dental records/x-rays to be released to the following dental office.

Release To:/From:

Additional family members to be included:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Vital Information about your Dental Insurance**

Our office is happy to help you file your insurance to receive the maximum dental benefits that you and your employer are paying premiums. Dental plans can vary from company to company, benefits varying according to the plan your employer has signed up for. Insurance companies base the amounts that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location. In other words, your insurance plan will pay only what it allows for each service, regardless of what the actual fee might be. Deductibles and co-payments are typically built into most plans and their required payment is strictly regulated by state law. Both our office and you, as the policy beneficiary, can be prosecuted if deductibles and co-payments are not collected. Your Human Resources Department can usually help you become familiar with your plan and its' restrictions. Our office will assist you in maximizing your dental benefits.

#### **Our responsibility to maximize your dental insurance:**

1. Complete your insurance claim and submit to your carrier within 24 hours of treatment.
2. Use current American Dental Association coding for correct reporting of procedures.
3. Accept direct payment from your carrier and keep track of balances.
4. If necessary, re-file your insurance a second time if no payment within 30 days.

#### **Your responsibility:**

1. To pay fees not covered by your plan at the time of treatment.
2. To provide our office with the correct information regarding your dental plan to allow for correct filing of claims. To have address, ID and group number of your insurance, along with a hard copy of your dental card.
3. To understand that your plan is a contract between you, your employer and your insurance carrier. Our office will do all we can to facilitate claims payment, however we do not have the power to make your plan pay.
4. To pay any account balance not paid by insurance after 2 billing attempts.
5. To give 24 hours notice if you cannot keep your scheduled appointment. There is a charge for late and broken appointments to cover overhead.
6. All accounts due in 30 days. 1 ½% interest on unpaid balance (18% annual rate).

### **Patients without Dental Benefits**

If you do not have dental coverage we do expect full payment at the time of service. We accept Visa, Mastercard, Discover, American Express, Care Credit, checks and, of course, cash. See a business assistant for details on care credit.

We thank you for choosing our office and we will do all we can to help you obtain the benefits you deserve if you have dental insurance.

**I hear by authorize payment directly from my insurance carrier to Shores Family Dentistry. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my treatment to third party payers.**

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# Shores Family Dentistry

4360 Boardwalk Drive Suite 100, Fort Collins CO 80525 – Phone: (970) 226-2920

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## NOTICE OF PRIVACY PRACTICES

### PATIENT ACKNOWLEDGMENT

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice include:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to disclose information.
- A description of other uses and disclosures that will be made only with my written authorization, and that I may revoke such authorization.
- My individual rights with respect to protected health information, and a brief description of how I may exercise these rights in relation to:
  - ✓ The right to complain to this practice and the Secretary of HHS if I believe my privacy rights have been violated. No retaliatory actions will be used against me in the event of such complaint.
  - ✓ The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - ✓ The right to receive confidential communications of protected health information.
  - ✓ The right to inspect and copy protected health information.
  - ✓ The right to amend protected health information.
  - ✓ The right to receive an accounting of disclosures of protected health information.
  - ✓ The right to obtain a paper copy of the Notice of Privacy Practices forms of this practice upon request.

This practice reserves all rights to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

Relationship to patient (if signed by personal representative of patient) \_\_\_\_\_