CASTLE PEAK DENTAL

ABOUT YOU

Today's Date: _____/_____/_____

Name: _____
Last First Middle

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: _____/_____/_____ Age _____
Month Day Year

Check one: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address: _____
Street/P.O. Box Apt. /Condo #

_____
City State Zip Code

Email Address: _____

Home Phone: (_____) _____ Cell: (_____) _____

Work Phone: (_____) _____ Ext. _____

How may we remind you of your upcoming appointments?
☐ Phone call ☐ Email ☐ Text Message

Employer: _____

Occupation: _____ How long there? _____

_____

When and where are the best times to reach you? _____

_____

Whom may we thank for referring you? _____

Other family members seen by us? _____

_____

_____

_____

Previous/Present Dentist: _____ Last visit _____

Name of person who lives nearby we should notify in the event of an emergency: _____

Relationship _____

Cell Phone: (_____) _____

Other Phone: (_____) _____

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

_____

Are you currently in pain? ☐ Yes ☐ No

Previous Dentist _____

Date of last dental care _____

Have you had any serious problem associated with any previous dental treatment? ☐ Yes ☐ No

Your current dental health is? ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone: (_____) _____

Date of last visit: _____/_____/_____
Month Day Year

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes please explain: _____

_____

Are you currently under a physician's care? ☐ Yes ☐ No

If yes please explain: _____

_____

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

How long? _____ How often? _____

Please list all medications being taken (Prescription or herbal):

_____

_____

_____

_____

_____

Check whether you have ever had any of the following?

Yes	No	
☐	☐	Artificial Bones/Joints
☐	☐	Artificial Valves
☐	☐	Asthma
☐	☐	Arthritis
☐	☐	Autism/Asperger's
☐	☐	Bisphosphonates
☐	☐	Blood Transfusion
☐	☐	Cancer/Chemotherapy, explain _____
☐	☐	Congenital Heart Defect
☐	☐	Rheumatic Fever, what type _____
☐	☐	Diabetes, what type _____
☐	☐	Difficulty Breathing
☐	☐	Drug/Alcohol Abuse
☐	☐	Emphysema
☐	☐	Endocarditis
☐	☐	Epilepsy/Seizures
☐	☐	Fever Blisters/Cold Sores
☐	☐	Heart Attack, when? _____
☐	☐	Stroke, when? _____
☐	☐	Mitral Vave Prolapse
☐	☐	Taking blood thinners
☐	☐	Pacemaker, when placed _____
☐	☐	Heart Murmur
☐	☐	Hemophilia/Abnormal Bleeding
☐	☐	Hepatitis, what type? _____
☐	☐	High/Low Blood Pressure
☐	☐	HIV/AIDS
☐	☐	Sinus Problems
☐	☐	Ulcers/Colitis
☐	☐	Sexually transmitted disease
☐	☐	Tuberculosis
☐	☐	Glaucoma

Please list any serious medical problems you've ever had:

_____

_____

_____

_____

Are you allergic to any of the following:

Yes	No	
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Penicillin
☐	☐	Latex
☐	☐	Erythromycin
☐	☐	Other _____

For Women:

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

If "Yes," what week? _____

Are you nursing? ☐ Yes ☐ No

I understand this information I have given today is correct to the best of my knowledge and that this information will be held in confidence. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

Signature _____

Thank you for filling out this form. It will help us treat you more effectively. If you have any questions at any time, please ask us. We are happy to help.

For Office Use Only

Doctor's comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CASTLE PEAK DENTAL

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; April 30, 2009).

P.O. Box 576 ~ Eagle, CO 81631 ~ (970) 328-1116

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Castle Peak Dental, Professional LLC

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: (print) _____

Relationship to patient: _____

Signature: _____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW.

DATE: INITIALS: REASON:

Castle Peak Dental
56 Market St. Suite 5, Eagle, CO 81631
970-328-1116

Written Financial Policy

Patient portion is due in full at each appointment. Returned check fees of $25.00 will be applied to each returned check.

As a condition of your treatment, financial agreements must be made in advance. If you choose to discontinue care before treatment is complete, any refund given will be determined upon review of your case. All emergency dental services and any dental services performed without previous financial arrangements must be paid for at the time services are rendered.

As a courtesy, we will file your insurance claims; however, we cannot accept responsibility of negotiating claims with your insurance company or any person. Our office makes every attempt to obtain current benefit information from your insurance carrier prior to your appointment. As the insured member, you are ultimately responsible for understanding your benefit structure and realizing that your insurance plan is a contract between your employer, the benefit provider and you. Please understand that verifying your dental insurance is not a guarantee of payment**. Our office will provide treatment based on what is best for you, not what your insurance will cover. You are responsible for your total obligation should your insurance benefits result in less than anticipated coverage.**

Outstanding insurance balances remaining after 60 days, will be billed directly to you**. I agree to be responsible for payment of all services rendered. It is our policy to turn unpaid accounts over to a collection agency when the accounts reach 90 days past due.** In the event a legal suit or outside collections are necessary to enforce payment of the account, you agree to pay for all collection fees and/or attorney's fees and court costs as may be deemed reasonable.

Payment Options

Cash, Check, Visa, MasterCard, American Express, Care Credit, Citi Card

We offer a 10% courtesy for those patients without insurance when paid on date of service with cash, check or credit card and paid in full. We cannot offer a 10% discount when paying with Care Credit.

Late/Cancellation Policy

At Castle Peak Dental, we value your time. To ensure all patients receive quality care, we ask that you arrive to all appointments 10 minutes prior to your scheduled appointment time. This allows us the necessary time to review your health history and any changes in your insurance benefits.

If you arrive more than 10 minutes late, we may not be able to complete all treatment that was scheduled.

If it is necessary for you to cancel an appointment, please do so with a 48 hour advance notice.

Privacy Practice Policy

I hereby authorize payment directly to Castle Peak Dental from the insurance benefit provider otherwise payable to me. I grant the right to Castle Peak Dental to release my dental history, and other pertinent information about my dental treatment to third party payers.

I have read and understand all policies and have asked any related questions.

_____ _____
Patient, Parent or Guardian Signature Date

_____
Printed Name

I hereby authorize the following individuals to bring my child to appointments and have indicated if they have authority to authorize treatment or changes in treatment plans:

_____ _____ can cannot authorize new treatment or treatment changes
Name Relationship

_____ _____ can cannot authorize new treatment or treatment changes
Name Relationship

Subscriber Name:_____ DOB:_____ Social: _____

Member ID: _____

Patient's Name: _____ DOB: _____

Employer:_____ Phone #:_____

Member ID: _____

Insurance Carrier: _____ Phone #: _____

Insurance Carrier Address: _____