Total Dental
HEALTH SOLUTIONS

Dr. John Feeley

Patient Name: _____ Birth Date: _____ SS# _____
Home Address: _____ City _____ State _____ Zip _____
Home # _____ Cell# _____ Work # _____ Employer _____
Email Address _____ Referred to us by: _____
Spouse's Name: _____ Spouse's SS# _____ Spouse's Birth Date: _____
Emergency Contact: Name, Relationship and Phone# _____

MEDICAL HISTORY

Name and Phone Number of Physician _____ Last Complete Physical _____
Please list any medications you are taking: _____

Do you or have you had any of the following diseases, medical conditions or procedures. *PLEASE MARK YES OR NO*

Y/N Heart Attack/Stroke	Y/N Thyroid Problems	Y/N Cancer/Tumors	Y/N Heart Surg/Pacemaker
Y/N Kidney Disease	Y/N Chemotherapy	Y/N Glaucoma	Y/N Heart Murmur
Y/N Emphysema	Y/N Diabetes Type 1 or 2	Y/N Hypoglycemia	Y/N Blood Disorder
Y/N Respiratory problems	Y/N HIV+/Aids/ARC	Y/N Biphosphonates	Y/N High/Low Blood Pressure
Y/N Arthritis/Rheumatism	Y/N Heart Disease	Y/N Tuberculosis TB	Y/N Stomach Problems/Ulcers
Y/N Sinus Problems	Y/N Bleeding Problems	Y/N Joint Replacement	Y/N Hepatitis
Y/N Frequent Headaches	Y/N Scarlet Fever	Y/N Alcohol/Drug Abuse	Y/N Asthma

Yes or No BEFORE DENTAL WORK, DO YOU REQUIRE PRE-MEDICATION FOR YOUR HEART/JOINT REPLACEMENT?

Please list any other surgeries or medical conditions you have been treated for in the past 10 years not listed above: _____

Do you have any allergies? Yes or No (If yes please circle)

Penicillin Tetracycline Codeine Aspirin Latex Sulfa Anesthetics Other _____

Do you use tobacco? Y/N How much? _____ How long? _____ Are you taking birth control pills? Y/N
Are you pregnant? Y/N How far along? _____ Are you nursing? Y/N

DENTAL INFORMATION

Are you in pain? Y/N **If yes, when did it begin?** _____
Please describe symptoms _____

Please indicate any of the following problems: __Discomfort, clicking or popping of the jaw __Lost/Broken filling(s) __Swollen or bleeding gums __Clenching/Grinding __Locking jaw __Sensitive teeth or gums __Bad breath __Blisters/Sores in or around the mouth __ Broken/chipped teeth Other: _____

New Patients: Last Dental Exam _____ Last Dental X-rays _____ How often do you brush? _____

How often do you floss _____ Reason for leaving previous practice? _____

Signature _____ **Date** _____

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OUR FINANCIAL POLICY

Please read carefully and initial each paragraph:

_____ **IF YOU HAVE NO INSURACE COVERAGE:**
PAYMENT IS EXPECTED AT THE TIME OF SERVICE

_____ **IF YOU HAVE PRIVATE INSURACE:** (e.g. Delta Dental, BC/BS, MetLife, Cigna, Aetna, Medicaid etc.) Your insurance policy is a contract between you, or your employer, and the insurance company. As a courtesy to you, we will file your claim(s) for reimbursement, and ESTIMATE our co-payment. CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. If your insurance company pays less than expected, you will be responsible for the difference. Patients who fail to provide sufficient insurance information will be required to pay in full upon receipt of services. Failure to pay the co-payment may result in rescheduling your appointment.

_____ **IF YOU HAVE DOUBLE COVERAGE:**
Double coverage does not guarantee that you will not owe any money toward dental care. CO-PAYMENTS AND DEDUCTIBLES, IF ANY, ARE DUE AT THE TIME OF SERVICE.

INSURANCE INFORMATION

Dental Insurance Name:_____

Insurance Phone Number:_____ Group #:_____ Plan #:_____

Insured's Name:_____ Date of Birth:_____

SS#:_____ Employer:_____ Relationship to Patient_____

_____ **MISSED APPOINTMENTS:**
A fee of $25 per ½ hour will be charged for missed appointments. CANCELLATIONS MUST BE MADE AT LEAST 24 HOURS IN ADVANCE. Some dental plans specify a specific fee for missed appointments.

Thank You! We will be happy to help you with any questions you may have.

SERVICE CHARGE
If I do not pay the entire balance within 30 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00). In the case of default of payment, I promise to pay any interest on balance due, a 35% collections fee, together with any additional collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Signature:_____ Date:_____
(Responsible Party)

Total Dental Health Solutions
6363 W. 120th Avenue, Suite 230
Broomfield, CO 80020
Ph: 303-635-0100

"HIPAA" Acknowledgement

I understand that under the Health Insurance Portability & 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

I have received, read and understand 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 Private 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: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date Initials Reason

_____