Prestige
DENTAL CENTERS

Patient Information (Confidential)

Name_____ _M F_
First Middle Last Sex

Address_____City_____

State_____Zip_____Email_____

SS#_____Birthdate_____Age_____

Phone: Home_____Work_____

Check Appropriate Box: __ Minor __ Single __ Married
__ Divorced __Widowed __ Separated

If College Student, Full time Part time

School Name_____City_____State_____

Patient's or Parent's Employer_____

Business Address_____

City_____State_____Zip_____

Spouse or Parent's Name_____

Employer_____Work Phone_____

Emergency Contact_____

Phone_____

Dental Insurance Information Only

Name of Insured_____

Relationship to Patient_____Home Phone_____

Birthdate_____SS#_____

Date Employed_____Employer Name_____

Union or Local #_____Work Phone_____

Employer's Address_____

City_____State_____Zip_____

Insurance Co._____Tel. #_____

Ins. Group #_____Policy / ID #_____

Ins. Co. Address_____City_____

State_____Zip_____Max. Annual Benefit?_____

How much is your deductible?_____

How much have you used this year? _____

Do you have any additional insurance ____ Yes ____ No

Ins Co._____Tel. #_____

Ins Group #_____Policy/ID#_____

Responsible Party

Name of Person Responsible For This Account_____

Relationship to Patient _____ Address _____

Home Phone_____SS#_____Driver's Liscense #_____

Birthdate_____Employer_____Work Phone_____

Is this person currently a patient in our office? ____ Y _____ N

X_____ _____
Signature of Patient or Parent if Minor Date

Prestige DENTAL CENTERS

YES NO

1. __ __Are you in good health?
2. __ __Have there been any changes in your general health within the past year?
3. Date of your last physical exam: _____
4. Physician's
Name_____
Address_____
Phone No. _____
5. __ __ Are you now under the care of a physician?
6. __ __Have you ever been hospitalized for any surgical operation or serious illness?
Please explain, _____
7. __ __Are you taking any medicines including nonprescription medicines?
If yes, what are you taking_____
_____
_____
8. __ __ Bruise easily or abnormal bleeding?
9. __ __ Have you ever required a blood transfusion
10. __ __Have you had a recent unintended weight loss/gain
11. __ __Have you ever needed deep cleaning/SRP?
12. __ __Have you ever had bisphosphonate drugs (for Cancer or Osteoporosis)
13. __ __Do you use tobacco? How much? Quit date?
14. __ __ Do you or have you ever had history of alcohol or substance abuse?
15. __ __Are you wearing contact lenses?
16. __ __Have you been diagnosed with Gum disease?
17. __ __Women: Are you pregnant?
__ __Are you nursing?
__ __Taking birth control pills
18. Are you allergic to or have you had serious reactions (other than stomach upset) to:
__ __Local anesthetics like Novocaine
__ __Penicillin or other antibiotics
__ __Barbiturates, sedatives or sleeping pills
__ __Aspirin or similar NSAIDs
__ __Any metals
__ __Latex / rubber/ Adhesive
Other (please list) _____
19. Do you have or have you had the following:

Cardiovascular
__ __ Rheumatic heart disease or rheumatic fever
__ __ Scarlet fever
__ __ Heart defect/murmur, Mitral valve prolapse
__ __ Stroke
__ __ Heart surgery, trouble, attack, or angina
__ __ Chest pain, shortness of breath
__ __ High / low blood pressure
__ __ Pacemaker
__ __ Fainting or dizzy spells
__ __ Anemia or blood disorders

Pulmonary
__ __ Sinus issues
__ __ Seasonal Allergies
__ __ Lung or breathing problems
__ __ Asthma or hay fever
__ __ Tuberculosis, persistent or bloody cough
__ __ COPD

Endocrine
__ __ Hepatitis, jaundice or liver disease
__ __ Stomach ulcer, reflux, IBS, Crohn's
__ __ Hypoglycemia
__ __ Kidney trouble
__ __ Hives or skin rash
__ __ Diabetes
__ __ Thyroid problems

Neuromuscular
__ __ Arthritis, rheumatism, fibromyalgia
__ __ Epilepsy or seizures,
__ __ Back problems
__ __ Chronic pain condition
__ __ Cortisone treatment
__ __ Glaucoma (Narrow/Wide)

Skeletal
__ __ Joint replacement or any implants?
Date_____
__ __ Head or neck trauma, whiplash

Systemic
__ __ Sexually transmitted disease
__ __ AIDS or HIV infection
__ __ Lupus
__ __ M.S.
__ __ Cold sores / fever blisters

Cancer
__ __ Chemotherapy for cancer or leukemia
What kind?
Diagnosis date?
__ __Radiation
__ __Surgery

Neurological
__ __ Nervousness or phobias
__ __ Chemical dependency, addictions
__ __ Hypochondriasis
__ __ Eating disorders, bulimia, anorexia
__ __ ADHD
__ __ OCD
__ __ Bipolar/Schizophrenia
__ __ Sleep disorder

20. __ __Do you have any disease, condition or problem not listed? Please explain

Patient Dental History

Reason for this visit_____
Date of last dental visit_____What was done?_____
Previous dentist name / location_____
Date of last complete series of dental x-rays_____
Circle all that you are concerned about / currently have:
Sensitivity to: Hot Cold Sweets

Cavities	Fear of dentistry	Headaches
Gum disease	Clicking jaw	Want whiter teeth
Broken teeth	Loose teeth	Want to save teeth
Broken fillings	Spacing	Poor dentistry
Missing teeth	Grinding/clenching	Want gentle dentist
Dark/Ugly teeth	Snoring / Apnea	Recession
Crooked teeth	Bleeding gums	Cosmetic dentistry
Bad breath	Jaw or face pain	Nothing

Prestige
DENTAL CENTERS

Dental History

We would like to get to know you better…
I am changing dentists because:
Check any that apply
__ Recently moved into this area from _____
__ Dr/staff personality __ Communication problem
__ Inadequate care __ Fee concern __ Insurance
__ Need a second opinion or better option on dental care
__ To find a dentist team who understands my needs
Where are you from originally? _____
Your occupation and job _____
Schools attended _____
Spouse's name & occupation _____
Children's names, ages _____
What's more fun than dental visits? _____
I have avoided dental care in the past because:
__ Fear of _____
__ Time commitment __ No perceived need
__ Financial commitment __ Trust factor
If you could change anything about your smile, what would you change?

_____

Are you interested in exploring (check any that apply):
__ Sleep apnea or Snoring Treatment Options to CPAP
__ Implants
__ I.V. Sedation and Sleep Dentistry
__ Oral Sedation(pill) and gas options
__ Smile Makeover -- Smile Analysis & Design
__ Why dental infections cause heart & other diseases
__ Ways to reduce or eliminate periodontal surgery (lasers)
__ Invisalign invisible orthodontic aligners
__ BriteSmile & ZOOM office whitening or home whitening
__ The best dental home care systems

How did you hear about us? Check any that apply
_ Convenient location (Saw sign on the road)
_ Family member already comes here _____
_ Referred by Friend? Who? _____
_Received a welcome letter in the mail
_ Google.com _ Yelp _ Facebook _ Other site (name)
_____
_ Newspaper _ Tv _ Radio _ Bus benches _ VA
_ Quality connection _ Implant Seminar _ Phone book
_ Other?_____

Authorization & Release
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to dental examination and any necessary records that are necessary for an accurate diagnosis. I authorize the dentist to use any treatment records, x-rays , models or photos for scientific, teaching or promotional purposes.
X_____Date_____
Signature of Patient or Parent if Minor

Additional Information

Doctor Notes:
- Health History Concerns
- Referrals
- Priorities
- Patient preferences

_____Date_____
Doctor signature

Prestige
DENTAL CENTERS

STATEMENT OF PRIVACY PRACTICES

We are dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your heath information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare

We use and disclose the information we collect from you only as allowed by the Heath Insurance Portability and Accountability Act. This includes issues relating to your treatment, payment, and our dental care operations. You may give written authorization for us to disclose your information to anyone you choose, for any purpose but it will never otherwise be given to anyone-even family members-without your written consent.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy and practices apply to all current and former patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations and comply with the law. This may include your name, address, telephone number(s), Social Security number, employment date, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, the information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. This includes issues in which we reasonably believe you may be a victim of abuse, neglect, domestic or other crimes. We are also obligated to provide information to law enforcement officials under certain circumstances.

We will not use your information for marketing purposes without your written consent.

We may use and/or disclose health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patent Rights

You have a right to get copies of your healthcare information; to obtain copies in a variety of formats; and to a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can, also, notify the U.S. Department of Human Services.

We thank you for being a patient at our practice. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

3208 N.Academy Blvd.Suite 110
Colorado Springs, CO 80917
719-597-3700

1700 N.Salem Ave.Suite B
Pueblo, CO 81001
719-582-4222

www.prestigedentalcenters.com

Prestige
DENTAL CENTERS

ACHNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I_____,have received a copy of this office's Notice of Privacy Practices.

_____ _____
Signature Date

Please check appropriate boxes to indicate where we may leave messages if we do not talk to you personally.

Work:
_____Co-Worker
_____Recorder

Home:
_____Other family members
_____Recorder
_____Cell Phone

For office Use Only: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign
_____Communications barriers obtaining the acknowledgement
_____Other Photographs
_____Self
_____Family

3208 N. Academy Suite 110
Colorado Springs, CO 80917

1700 N. Salem Ave. Suite B
Pueblo, CO 81001

www.prestigedentalcenters.com

FINANCIAL POLICY:

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. Any difference in payment from your insurance company and your account balance is your responsibility.

Insurance assignment: Insurance benefits are estimates only. I understand I am responsible for any co-payments and deductibles, as well as any procedures not covered by my insurance company. I authorize payment directly to Prestige Dental Center/Prestige Denture Clinic. I understand I am responsible for all costs of treatment. I grant the right for Prestige Dental Centers/Prestige Denture Clinic to release my dental/medical histories and other information about my dental treatment to third party payers and/or health practitioners. If a bill is unpaid 90 days or more, a collection agency will be used and I will be responsible for all collection costs and legal fees accumulated on my behalf or that of my dependents.

Appointment cancellations with less than 48 hrs notice or failed appointments will have a $50 charge for an appointment with a hygienist and a minimum of $50 with a maximum of $300 for an appointment with a dentist, depending on the length of the appointment. (Cancelations due to weather will not be charged)

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am aware past due accounts will be subject to a charge of 1.5% per month interest. I am responsible for all collection costs insured by the dental office and on a returned check, a fee of $30.00.

PLEASE NOTE ***Divorced Parents:*** The parent who is present with the patient at time of appointment will be considered the “financially responsible party” and will be accountable for all fees incurred.

Signature of Patient or Responsible Party:_____ Date:_____

MEDICAID PATIENTS: I understand I must submit my current Medicaid identification card along with a picture ID on the day service is rendered.

I am aware that I am financially responsible for services not covered by the Colorado Medicaid Dental Program.

Colorado Medicaid Dental Program has a maximum of $1000 for adults 21 years of age and older. I am aware that I am financially responsible for any services that exceed the $1000 maximum.

I also understand after Medicaid has processed the claim there may be a portion of the balance which will be my responsibility. I agree to pay this balance within 30 days.

_____

Member Signature Date

Parent or Guardian Signature (if the member is under the age of 18) Date

Consent For Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis including consultation with adjunct healthcare providers as he deems necessary.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance, including other healthcare providers, as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I understand that each appointment I will have is set-aside specifically for me. If I am more than 10 minutes late I may not be seen. If I fail to notify the office more than 48 hours ahead of time of canceling an appointment or do not arrive for an appointment, a broken appointment fee of $45.00 will be assessed.

5. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. It is my responsibility to know my insurance benefits and plan parameters, and I will be responsible for telephoning them myself, should I have any questions. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand my insurance carrier may pay less than the actual bill for services. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received as agreed upon, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

_____ _____

Patient Signature Date

_____ _____

Parent or Responsible Party Relationship to Patient

3208 N. Academy Blvd. Suite #110
Colorado Springs, CO 80917
719-597-3700

1700 N. Salem Ave.Suite B
Pueblo, CO 81001
719-582-4222

Prestigedentalcenters.com