



### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)  
 Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell) \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

### Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> AIDS               | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Allergies _____    | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Growths             | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Hay Fever           | Due date: _____                               | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Radiation Treatment  | OTHER: _____                                |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Blood Disease      | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Smoke              |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatism           |   |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems       |   |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Stomach Problems     |   |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stroke               |   |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Tuberculosis         |   |
|   | <input type="checkbox"/> Mental Disorders    | <input type="checkbox"/> Tumors               |   |

Please list all Medications: \_\_\_\_\_

- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative

Dental Office  Brochure  Walk In  School  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI  
Insured's Birth Date: \_\_\_\_\_ SS #: \_\_\_\_\_ ID #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
Insurance Plan Phone #: \_\_\_\_\_

#### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI  
Insured's Birth Date: \_\_\_\_\_ SS #: \_\_\_\_\_ ID #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
Insurance Plan Phone #: \_\_\_\_\_

### Consent for Services

All emergency dental services, or any dental services performed must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or their assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## Financial Policy

Initial \_\_\_\_\_

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by your insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination and any changes in insurance coverage may alter my estimate.

In consideration for the professional services rendered to me, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or their assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

## Appointment Policy

Initial \_\_\_\_\_

At Cherry Creek Dental Spa, a scheduled appointment is the amount of time that we have reserved for you, the patient. Some offices will double and triple book the appointments to ensure a full schedule. We have chosen not to schedule that way in an effort to present a quality dental experience at our office.

We understand that schedules change and situations arise that may make it difficult to keep appointments. However, it is the patient's responsibility to give us advanced notice so that we are able to give the reserved appointment time to another patient. As a courtesy, we provide reminders for appointments. In the event our systems are unable to remind you, it remains your responsibility to contact us regarding changes.

**The following situations may lead to a Missed Appointment Fee (MAF) of \$50 per half hour with a minimum of \$50:**

- **Less than 2 business days' notice.** All appointment changes should be made with a phone conversation or in person. If we are not available, please leave a voice message.
- **Failed Appointments (no notice given)** When no prior notice is given we retain the right to cancel any additional upcoming appointments until payment of MAF is made. Further abuse of our policy may lead to patient dismissal from our practice.
- **Late arrival – leading to rescheduling of appointment.** Patients that arrive too late to do all or part of the treatment scheduled.
- **Failure to take required pre-med.** We retain the right to charge for appointment time when we are unable see the patient due to their failure to take pre-medication as instructed.

## Electronic Correspondence

Accept \_\_\_\_\_ Decline \_\_\_\_\_

I understand that I may receive electronic correspondence (primarily emails) from Cherry Creek Dental Spa. This may include appointment information, billing statements and other patient/guarantor correspondence. Cherry Creek Dental Spa does utilize an outside service for automated appointment reminders (Revenue Well). Cherry Creek Dental Spa will not share your email information with any outside vendors.

## Consent

I have read the above conditions of treatment and payment and agree to their content. I have been given the opportunity to ask questions to my satisfaction regarding these policies.

Print Patient Name: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of patient, parent or guardian

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Cherry Creek Dental Spa  
155 South Madison Street  
#220  
Denver, CO 80209

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 health care 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 physical certifications.

I have been offered 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 that you are not required to agree to my request restriction but if you do agree then you are bound to abide by such restrictions.

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Patient Name (Printed)

Relationship to Patient (self/parent/guardian)

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Signature

Date

*I am over the age of 18 and give my consent to Cherry Creek Dental Spa to (please check)*  
*Discuss my dental bill with my parent(s)*  
*Discuss my dental treatment/care with my parent(s)*

Office Use Only:

I attempted to obtain the patients signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below.

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Name

Date

Reason