INCREDIBLE Smiles™

Welcome to our office

Your name _____Prefer to be called _____
Address _____
City/State/Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ Email Address _____
Date of Birth _____ Social Security # _____
Your Occupation _____ Marital Status _____
Your Employer _____
How did you hear about Incredible Smiles? _____

Do you have dental insurance? _____ (If yes please complete the following)
Policy Holder Name: _____ Policy Holder Date of Birth: _____
Policy Holder Employer: _____Insurance Company Name: _____
Insurance Phone Number: _____ Member ID Number: _____
Group Number: _____
Insurance Company Address: _____

****We are a fee-for-service practice and are not contracted with any insurance companies. Payment is due at the time of service, and we are happy to submit your insurance claim on your behalf. Your insurance company will reimburse you directly according to your plan's benefits.**

Medical History

Are you experiencing dental pain or discomfort at this time? _____
Have you been hospitalized or had any surgeries during the past two years? _____
Have you been under the care of a medical doctor during the past two years? _____
Please list any medications you are currently taking _____
_____
Are you allergic or made sick by Penicillin, aspirin, Codeine, or any other drugs or medications? _____

If yes, please list _____
_____
Have you ever had any excessive bleeding requiring special treatment? _____
Have you ever had a negative experience in a medical office? _____

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Please provide a date for the following:

Glaucoma (Wide or narrow angle?) _____
Angina Pectoris _____
Tuberculosis (TB) _____
High Blood Pressure (What is normal for you?) _____
Chemotherapy (Cancer, Leukemia) _____
*Heart Murmur (Are you functional or nonfunctional?)_____
*Artificial Joint/ Joint Replacement _____
*Mitrovalve Prolapse (MVP) _____
*Rheumatic Fever _____

Please indicate yes with an "X" for the following:

HIV	_____	Scarlet Fever	_____	Cortisone medicine	_____
AIDS	_____	Artificial heart valve	_____	Psychiatric treatment	_____
Liver disease	_____	Heart failure	_____	Drug addictions	_____
Hepatitis A	_____	Heart Disease or Attack	_____	Epilepsy	_____
Hepatitis B	_____	Heart pacemaker	_____	Fainting	_____
Hepatitis C	_____	Heart surgery	_____	Nervousness	_____
Yellow Jaundice	_____	Hay Fever	_____	Anorexia	_____
Blood transfusion	_____	Allergies or Hives	_____	Bulimia	_____
Hemophilia	_____	Chronic cough	_____	Diabetes (Type I or II)	_____
Anemia	_____	Sinus trouble	_____	Thyroid disease	_____
Sickle Cell disease	_____	Asthma	_____	Ulcers	_____
Kidney trouble	_____	Emphysema	_____	X-ray or Cobalt treatment	_____
Stroke	_____	Arthritis	_____	Cold sores	_____
Rheumatism	_____	Pain in jaw joints	_____	Sleep Apnea	_____

Congenital heart lesions _____
*Have you ever taken Fen Phen or Redux and if so, did you have a cardio exam? _____

Please check (X) if you have been administered orally or intravenously the following prescriptions:

Actonel ____ **Fosamax** ____ **Fosamax Plus D** ____ **Boniva** ____ **Skelid** ____
Didronel ___ **Aredia** _____ **Zometa** _____ **Bonefos** ____

When you walk up stairs or take a walk, do you ever stop because of pain in your chest, shortness of breath, or because you are very tired? _____
Has your medical doctor ever said you have cancer or a tumor? _____
Do you ever wake up from sleep short of breath? _____
Have you ever been told you snore? _____
Can you breathe through your nose? _____

Do you feel rested when you wake up? _____
Do you or have you worn a CPAP? _____
Have you been diagnosed with Sleep Apnea? _____
Do you take Ambien, Benadryl, Tylenol PM, or any sleep aid regularly? _____
Do you have any disease, condition, or problem not listed that you wish to discuss with us? _____
For women: Are you pregnant? _____

Name and number of current physician _____

*** Indicates need for pre-medication**

The information I have given is true and correct to the best of my knowledge. I will inform the doctor, assistant, or hygienist if there is any change in my medical status.

_____ _____

Signature of guest or guardian **Date** **Witness Signature** **Date**

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EPWORTH SLEEPINESS SCALE: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale and write the most appropriate number for each situation.

0= would never doze **1= slight chance of dozing**
2= moderate chance of dozing **3= high chance of dozing**

Sitting and reading _____
Watching TV _____
Sitting, inactive, in a public place (theater, meeting, etc) _____
As a passenger in a car for an hour without a break _____
Lying down to rest in the afternoon when circumstances permit _____
Sitting and talking to someone _____
Sitting quietly after lunch without alcohol _____
In a car, while stopped for a few minutes in traffic _____

Guest Name _____ **TOTAL** _____

I hereby apply for acceptance as a patient of Incredible Smiles. I am aware dental treatment will be rendered by the licensed dentist and/or hygienist.

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Appointments

I understand if I fail to pay fees, fail three or more appointments, or cancel appointments outside the expected time frame, a fee may be accrued or I may be dismissed from your office.

Records/Tests/Procedures

I will make known any diseases, allergies, or unusual reactions to drugs or medications that have occurred to me in the past. If my health or medications change, I will inform the doctor/hygienist/assistant at my next appointment without fail. I understand that if, during the course of my treatment in this facility, a dentist, hygienist, or employee has an accidental exposure to my blood, a specimen may be requested and tested for the presence of blood-borne diseases. I understand that I may refuse such a blood test and it will not affect my status as a client. The tests will be done at no charge and will not imply that I carry a disease or am at high risk. The result of such tests or exposure will remain confidential and will not become a part of my permanent record. I will consent to the use of photography, x-rays, impressions, and other laboratory diagnostic tests where they are indicated for the purpose of diagnosing and planning treatment. I consent to the use of local anesthetics and other methods of pain control to make me more comfortable while receiving treatment.

I understand unless otherwise arranged, full payment for professional service is required on the day the service is rendered.

I understand copies of my x-rays, photos, and dental records are available upon request. A signed consent form is required before release.

_____ _____

Signature of guest or guardian **Print name**

_____

Date

www.IncredibleSmiles.com
4150 Darley Avenue Boulder, CO 80305 phone: 303.499.0013 fax: 303.499.0023

Privacy Practices Acknowledgement

(Our complete privacy practices policy follows this page)

The Health Insurance Portability and Accountability Act of 1996 ("HIPPA") requires health care providers to give patients a copy of the Notice of Privacy Practices of Incredible Smiles and make a good faith effort to obtain an acknowledgement of receipt of same. *You may refuse to sign this acknowledgement form.*

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Incredible Smiles. Our Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read our full Notice.

ACKNOWLEDGMENT OF RECEIPT: I acknowledge receipt of the Notice of Privacy Practices of Incredible Smiles.

_____
Patient Printed Name

_____ _____
Patient/Guardian Signature Date

If other than the patient, specify relationship
_____

FOR INTERNAL USE ONLY: INABILITY TO OBTAIN ACKNOWLEDGMENT

If Incredible Smiles is not able to obtain the patient's or patient's guardian's acknowledgment, record the good-faith effort made to obtain acknowledgment and the reason acknowledgment was not obtained:

Please describe the efforts taken to obtain acknowledgment: _____
_____

Please describe the reason acknowledgment was not obtained: _____
_____

_____
Recording Staff Member Name

_____ _____
Recording Staff Member Signature Date

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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.

OUR PROMISE

This is not meant to alarm you! Quite the opposite. It is our desire to communicate to you that we are taking the new Federal (HIPAA – Health Insurance Portability and accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

SO WHAT HAS CHANGED? WHY A PRIVACY POLICY NOW?

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information... This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws; we want you to understand our procedures and your rights as our valuable guest.

We will use and communicate your health information only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

HOW YOUR HEALTH INFORMATION MAY BE USED

TO PROVIDE TREATMENT- We will use your health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

TO OBTAIN PAYMENT- We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

TO CONDUCT HEALTH CARE OPERATIONS- Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by guests receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

IN PATIENT REMINDERS- Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our guests to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us you do not want to receive these reminders).

ABUSE OR NEGLECT- We will notify government authorities if we believe a guest is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with a guest's agreement.

PUBLIC HEALTH AND NATIONAL SECURITY- We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

FOR LAW ENFOREMENT- As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

FAMILY, FRIENDS AND CAREGIVERS- We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medication, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION- Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

DentaPATIENT RIGHTS

This new law is careful to describe that you have the following rights related to your health information.

RESTRICTIONS- You have the right to request restrictions on certain uses and disclosure of your health information. Our office will make every effort to honor reasonable restriction preferences from our guests.

CONFIDENTIAL COMMUNICATIONS- You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

INSPECT AND COPY YOUR HEALTH INFORMATION- You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We require a signed consent form to release these records.

DOCUMENTATION OF HEALTH INFORMATION- You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14th, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time.

REQUEST A PAPER COPY OF THIS NOTICE- You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our guests receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.