ASSOCIATES IN PERIODONTICS
periodontics and dental implants

Date: _____ / _____ / _____
mm dd yy

PATIENT INFORMATION

Patient's Full Name: _____ Date of Birth: _____ / _____ / _____
(*First name, middle name and last name*) *mm dd yyyy*

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: _____ City/ State/ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Preferred contact for appointment confirmation (check one): ☐ home ☐ work ☐ cell ☐ email

General DDS: _____ Whom may we thank for referring you? _____

EMPLOYMENT INFORMATION

Patient/ Parent

Employer: _____

Address: _____

City/ State/Zip: _____

Business Phone: _____

Social Security #: _____

Spouse/ Parent

Employer: _____

Address: _____

City/ State/Zip: _____

Business Phone: _____

Social Security #: _____

INSURANCE INFORMATION (Dental Only)

Name of Insured: _____ Insured DOB: _____ / _____ / _____
mm dd yyyy

Social Security # or ID# of Insured: _____ Group #: _____

Insurance Company's Address: _____ City/ State/ Zip: _____

CONSENT TO SERVICES

I consent to treatment necessary or desirable to the care of the patient first named above, for the diagnosis of dental disease, deformity, or treatment of dental emergency. These procedures may include radiographs, models, and intraoral examination. In the case of a dental emergency, I consent to the use of local anesthetic and relaxants for completing the necessary dental treatment. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, at the time of service, unless other arrangements are made in advance.

I understand this office is required by law to maintain the privacy of my personal health information and provide me, upon request, with the legal duties and privacy practices with respect to my personal health information.

_____ _____ _____ / _____ / _____
Signature of patient, parent or guardian *Relationship to patient* *mm dd yy*

_____ _____ _____ / _____ / _____
Signature of patient, parent or guardian *Relationship to patient* *mm dd yy*

EMERGENCY CONTACT INFORMATION

Whom may we contact in case of an emergency? _____

Relationship to you: _____ Contact Phone: _____

DENTAL HISTORY & INFORMATION

Do your gums bleed when you brush or floss? ☐ Yes ☐ No

Are your teeth sensitive to cold, hot, sweets or pressure? ☐ Yes ☐ No

Does food or floss catch between your teeth? ☐ Yes ☐ No

Is your mouth dry? ☐ Yes ☐ No

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

Date of last dental exam: _____ / _____ / _____

Do you have brux or grind your teeth? ☐ Yes ☐ No

Do you have sores or ulcers in your mouth? ☐ Yes ☐ No

Do you wear dentures or partials? ☐ Yes ☐ No

Have you ever had serious injury to your head or mouth? ☐ Yes ☐ No

Have you ever had orthodontic (braces) treatment? ☐ Yes ☐ No

What was done at the last dental exam? _____

Date of last dental x-rays: _____ / _____ / _____

What is the primary reason for your visit today? _____

MEDICAL HISTORY & INFORMATION

Family Physician: _____ Practice Name: _____

Address: _____ City/ State/ Zip: _____

Weight: _____ lbs (*required for local anesthesia*)

How is your current health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor Are you currently under the care of a physician? ☐ Yes ☐ No

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ Yes ☐ No Is so, for what? _____

Are you currently taking or have you taken any prescription or over the counter medications? ☐ Yes ☐ No If yes, please list all, including vitamins, natural or herbal preparations and/ or diet supplements: _____

_____

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ Yes ☐ No Date: _____ / _____ / _____

If yes, were there complications? ☐ Yes ☐ No

Are you currently taking or scheduled to begin taking either of the medications Alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No

Do you take controlled substances (drugs)? ☐ Yes ☐ No Do you use tobacco of any kind? ☐ Yes ☐ No

For Women Only Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Please mark all that apply:

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetic
- ☐ Erythromyein
- ☐ Jewelry
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline

Conditions:

- ☐ Alcohol abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial heart
- ☐ Asthma
- ☐ Bisphosphonates
- ☐ Blood thinners
- ☐ Blood transfusion
- ☐ Cancer/Chemo
- ☐ Congenital heart defect
- ☐ Diabetes
- ☐ Difficulty breathing
- ☐ Drug abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting spells
- ☐ Fever blisters
- ☐ Frequent headaches
- ☐ Glaucoma
- ☐ HIV +/ AIDS
- ☐ Hay fever
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Mitral valve
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pace maker
- ☐ Premed – heart
- ☐ Premed - joint
- ☐ Psychiatric problems
- ☐ Radiation therapy
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease

Other conditions/ problems not listed: _____

_____

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APPOINTMENT & FINANCIAL COMMITMENT

Thank you for choosing our office for your dental needs. Please read the following information carefully. If you have any questions, please direct them to our Insurance Coordinator.

Dental treatment is an excellent investment in an individual's well-being. Financial concerns should not be an obstacle in obtaining this important care. We recognize that many people are concerned about the affordability of dental care. Therefore, we are happy to provide several payment options.

To best meet the needs of our patients, Associates in Periodontics is an "*On Time Dental Practice"*. When we schedule an appointment for you, two events occur:

1) We will reserve that appointment time for you in our appointment book
2) We trust that you will arrive on time for that appointment.

If you are late for an appointment, we will do our best to fit you in our schedule, however, it may be necessary for us to reschedule your appointment. We will likewise do our best to remain on time however, please keep in mind that we are a surgical practice and circumstances beyond our control can arise so your patience and understanding are appreciated.

Please note that appointments rescheduled or cancelled less than 24 hours before their schedule time may result in a fee in the amount of 40% of the scheduled procedure. Three or more failed appointments may result in your dismissal from the practice.

Office Hours

Monday - Thursday	8:00 AM – 5:00 PM (12::00 – 1:00 PM closed for lunch)
Fridays	Closed

Should you have appointment needs, concerns or questions regarding your account, please do not hesitate to contact us.

As a condition of treatment by our office, all fees are due and payable at the time of service.

We accept credit cards (Discover, Visa, and MasterCard), debit cards, cash and personal checks ($50 fee for returned checks). For your convenience, we also accept Care Credit. Please speak to our Insurance Coordinator for information regarding this outsourced financial plan.

Please initial after each statement to acknowledge that you have read and understand the following:

1. In-Network Insurance and how we work with these companies

We are contracted with **Aetna, Anthem Blue Cross Blue Shield, Delta Premier, Delta Dental PPO, MetLife, Principal, and United Concordia**. We will gladly process your insurance claim to help you receive the full benefits of your coverage as a courtesy to you. However, you must complete the insurance section of our New Patient Form in its entirety. We will send a request for pre-authorization/ pre-estimate for procedures other than maintenance cleanings but trust that you will check with your insurer to find out the details and/ or limits of coverage. It can take 1-4 weeks to hear back from your insurance company so we will try to schedule your appointments accordingly. We cannot make any guarantee of estimated coverage or payment but please know that we will do everything possible to see that you received the full benefits of your policy. The estimated amount not covered by your insurance may be paid by one of the following payment options and we will be happy to work with you to plan the most appropriate arrangements for your budget.

Please be aware that **we are not a Medicaid/ Medicare provider**. This also includes plans that are driven by either program. Delta Dental CHP+ and any Delta Dental Medicare Plans fall under this category. As part of our Opt-Out agreement, we must

inform you in advance that we will not bill Medicare nor will you be able to submit a claim for reimbursement from Medicare. Should you choose to have treatment in our office, you may take advantage of our other payment options listed.

Option 1: You may choose to pay for our services in full at time of service by cash, check, debit, credit or Care Credit card. We will submit all claims to your insurance as a courtesy to you and will have your insurance company reimburse you directly.

Option 2: We will **estimate** as closely as possible your portion and ask you to pay the estimated portion on the day of services. You will receive an EOB (Explanation of Benefits) detailing what amount your insurance covered and payment from your insurance comes directly to us from your insurance. If you have over or under paid, we will either send a statement requesting the balance or a refund check for the overpayment.

_____ *Patient or guardian's initials*

2. Out-of-Network Insurance and how we work with you

Out-of-network simply means that our office is not contracted with your insurance company and consequently is not obligated to accept fees according to their fee schedule. You will be responsible for paying your co-pay percentage as well as any remaining balance not covered by their fee schedule.

_____ *Patient or guardian's initials*

3. Your insurance company is required by the Colorado Insurance Commissioner to process, pay or reject all insurance claims within 30 days. We guarantee accurate filing based on the information you provide us. After 60 days, if your insurance company has not reimbursed our office, the responsibility reverts to you to be paid within 10 days of receiving a statement. If the insurance company requires any action on your part, we will contact you immediately. **Please note – our relationship is with you, not your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status. We charge a 1.5% finance charge per month on the balance of the account after 3 months, each time we send a statement.** Please speak to our Insurance Coordinator for any adjustments.

_____ *Patient or guardian's initials*

4. We do not automatically pre-authorize treatment, but highly recommend it. If you would like to receive an Estimate of Dental Benefits from your insurance company, please inform the Insurance Coordinator. It may take your insurance company 4-6 weeks to process the request but once we receive the estimate, we will contact you to discuss payment arrangements.

_____ *Patient or guardian's initials*

In consideration of the professional services rendered, I agree to accept responsibility for the payment of such services, and I agree to pay all legal costs including collection fees and attorney fees if I fail to pay my account. I grant by permission to you, or your assigned, to telephone me at home or work to discuss matters related to this form. I have read and agree to the above conditions.

Patient's Full Name : _____

(Please print full name - first name, middle name and last name)

Signature: _____ Date: _____ / _____ / _____

Signature of patient or guardian *mm* *dd* *yy*

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HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

This notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/ date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ Yes ☐ No

May we leave a message on your answering machine at home or on your cell phone? ☐ Yes ☐ No

May we discuss your medical condition with any member of your family? ☐ Yes ☐ No

If yes, please name the members allowed: _____

Patient's Full Name: _____
(Please print full name - first name, middle name and last name)

Patient's Signature: _____ Date: _____ / _____ / _____
mm dd yy

Parent/ Guardian Name: _____

Parent/ Guardian's Signature: _____ Date: _____ / _____ / _____
mm dd yy

Full Name of Witness: _____
(Please print full name - first name, middle name and last name)

Signature of Witness: _____ Date: _____ / _____ / _____
mm dd yy

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MEDICARE PRIVATE CONTRACT

with

ASSOCIATES IN PERIODONTICS

Participating dentist with this company:
Jennifer R. Merritt, DDS

By signing this contract I understand and agree that I will not submit (or request that my oral surgery or periodontal services doctor submit) a claim to Medicare or its agents for services provided by Jennifer R. Merritt, DDS, even if such services would otherwise be covered.

I agree to be fully responsible, through insurance or otherwise, for payment of services rendered by Jennifer R. Merritt, DDS, and I understand that no claims will be submitted to Medicare and no Medicare reimbursement will be provided for these services.

I understand that there are no limits specified by Medicare as to the amounts that may be charged by the oral surgery or periodontal services doctor for services provided.

I understand that Medigap plans do not, and other health and medical care insurance plans may elect not to, make payments for such services.

I understand that I have the right to have services provided by other oral and periodontal surgeon or other practitioners for whom Medicare payment would be made, and that I am not compelled to enter into private contracts that apply to covered care furnished by other health care professionals who have not opted-out.

I understand that Jennifer R. Merritt, DDS is excluded from participation in the Medicare program under Section 1128 of the Social Security Act or pursuant to any other legal authority.

Patient's Full Name : _____
(*Please print full name – first name, middle name and last name)*

Patient's Signature: _____ Date: _____ / _____ / _____
mm dd yy

Full Name of Witness: _____
(Please print full name – first name, middle name and last name)

Signature of Witness: _____ Date: _____ / _____ / _____
mm dd yy

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RELEASE OF RECORDS

This notice allows Associates in Periodontics to release dental and/or financial information to a named relative or contact that may call on your behalf, requesting this information.

I, _____ hereby authorize Associates in Periodontics to disclose/ release information for ☐ **dental** ☐ **financial** or ☐ **both**, pertaining to me, to the following persons:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

May we keep your referring dentist informed of the treatment you were sent to us for? ☐ Yes ☐ No

Primary dentist or other physician you would like to release records to:

1. _____ Phone number: _____
2. _____ Phone number: _____
3. _____ Phone number: _____
4. _____ Phone number: _____

Patient's Full Name: _____ Date of Birth: _____ / _____ / _____
(*Please print full name - first name, middle name and last name*) *mm dd yy*

Signature of Patient: _____ Date: _____ / _____ / _____
mm dd yy

Parent/ Guardian's Name: _____

Signature of Parent/ Guardian: _____ Date: _____ / _____ / _____
mm dd yy