COLLEEN S. CARTER, D.D.S.

3955 E. Exposition Avenue, Suite 218, Denver, Colorado 80209

Patient Information

Date: ______________________ Cell Phone: _____________________ Alternate Phone: _________________

Name (Last, First, MI): ____

Address: ____

City: _______________________________ State: ________________ Zip: _______________________________

Birthdate: ___________________________ Sex: ☐ M ☐ F Age: ____________ SSN: _______________________

☐ Married ☐ Partnered ☐ Single ☐ Widowed ☐ Minor E-mail: _______________________________________

Patient Employer/School: _________________________________ Occupation: __________________________

Employer Phone Number: ____

Whom may we thank for referring you? ____

In case of emergency, who should be notified? ___________________________ Phone: __________________

Primary Insurance

Person Responsible for Account (Last, First, MI): ____

Relation to Patient: _______________________ Birthdate: _____________________ SSN: _____________________

Address: ____

City: ________________________________ State: ____________________ Zip: _______________________________

Phone: ____

Insurance Company: ______________________________________ Phone: _____________________________________

Subscriber ID: ______________________________________ Group Name: _____________________________________

Group Number: ___________________________________ Additional Insurance? ________________________________

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with and assign directly to my insurance company(ies) (if applicable) Dr. Carter and all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above- named doctor may use my health care information and may disclose such information to the above- named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature: ____ Date: ________________________

Printed Name: ____ Relationship: __________________

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Dental Health History & Medical History

Date: ________________ Name: ______________________________________ Birthdate: __________________

Reason for visit ____________________________________ Date of last dental care ______________________________

Former Dentist ____________________________________ Date of last dental x-rays _____________________________

Address ____

Dental History

Check (✓) if you have had problems with any of the following:

☐ Bad Breath
☐ Bleeding Gums
☐ Clicking or popping jaw
☐ Food collection between teeth
☐ Grinding Teeth
☐ Loose or broken teeth/fillings
☐ Periodontal treatment
☐ Poor Dental Health
☐ Sensitivity to cold/hot
☐ Sensitivity sweets/pressure
☐ Sleep apnea
☐ Snoring
☐ Sores or growths in mouth
☐ Unhappy with dentures
☐ Unhappy with your smile

Explain any above ____

____

____

How often do you floss? _____________________________ How often do you brush? _____________________________

Medical History

Physicians Name ____________________________________ Date of last visit ___________________________________

Do you have any current health problems? ☐ Yes ☐ No

If yes, please explain ____

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, please explain ____

Have you had any blood transfusions? ☐ Yes ☐ No

If yes, give approx dates ____

Have you ever taken any of the group of drugs collectively referred to as “fen-phen”? These include combinations of Tonimin, Adipex, Fasten (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.)

☐ Yes ☐ No

Women

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Menopause? ☐ Yes ☐ No

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Dental Health History & Medical History

Check (✓) the following which you have had, or presently have:

☐ Anaphylaxis	☐ Cortisone Treatments	☐ Herpes	☐ Respiratory Disease
☐ Anemia	☐ Cough, Persistent	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Arthritis, Rheumatism	☐ Cough up blood	☐ HIV/ AIDS	☐ Scarlet Fever
☐ Artificial Heart Valves	☐ Diabetes	☐ Jaw Pain	☐ Shingles
☐ Artificial Joints	☐ Discolored teeth	☐ Kidney Disease	☐ Shortness of breath
☐ Asthma	☐ Epilepsy	☐ Marijuana Use	☐ Skin Rash
☐ Atopic (Allergy prone)	☐ Fainting	☐ Liver Disease	☐ Spina Bifida
☐ Back Problems	☐ Food allergies	☐ Mitral Valve Prolapse	☐ Stroke
☐ Blood Disease	☐ Glaucoma	☐ Nervous Problems	☐ Surgical Implant
☐ Braces	☐ Head/ ear/ neck aches	☐ Pacemaker	☐ Swelling of feet/ ankles
☐ Cancer	☐ Heart Murmur	☐ Psychiatric care	☐ Thyroid Problems
☐ Chemical Dependency	☐ Heart Problems	☐ Radiation Treatment	☐ Tobacco Use
☐ Chemotherapy	☐ Hemophilia	☐ Rapid weight gain/loss	☐ Tonsillitis
☐ Circulatory Problems	☐ Hepatitis	☐ Recreation Drugs	☐ Tuberculosis
			☐ Venereal Disease

Is there any other issue or concern you would like to speak to the doctor about? ☐ Yes ☐ No

If yes, please describe____

____

List medications you are currently taking

____

____

Pharmacy Name _________________________________

Phone ______________________________________

Allergies

☐ Aspirin	☐ Penicillin
☐Barbiturates	☐ Sulfa
☐ Codeine	☐ Latex
☐ Erythromycin	☐ Local Anesthetic
☐Nitrous Oxide	☐ Other ________________

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ____ **Date** __________________

Parent/Guardian Signature ____ **Date** __________________

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Comfort Level Assessment

Can you tell us how anxious you get, if at all, with each dental visit?

Please indicate by marking the appropriate box:

1. If you went to the Dentist for TREATMENT TOMORROW, How would you feel?

❑ Not Anxious	❑ Slightly Anxious	❑ Fairly Anxious	❑ Very Anxious	❑ Extremely Anxious

2. If you were sitting in the WAITING ROOM (waiting for treatment), How would you feel?

❑ Not Anxious	❑ Slightly Anxious	❑ Fairly Anxious	❑ Very Anxious	❑ Extremely Anxious

3. If you were about to have a TOOTH DRILLED, how would you feel?

❑ Not Anxious	❑ Slightly Anxious	❑ Fairly Anxious	❑ Very Anxious	❑ Extremely Anxious

4. If you were about to have your TEETH SCALED AND POLISHED, how would you feel?

❑ Not Anxious	❑ Slightly Anxious	❑ Fairly Anxious	❑ Very Anxious	❑ Extremely Anxious

5. If you were about to have a LOCAL ANAESTHETIC INJECTION in your gum, above an upper back tooth, how would you feel?

❑ Not Anxious	❑ Slightly Anxious	❑ Fairly Anxious	❑ Very Anxious	❑ Extremely Anxious

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Consent for Use and Disclosure of Health Information

SECTION A: PATIENT GIVING CONSENT

Name ____

Address ____

Phone ____

Social Security # ____

E-mail Address ____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of privacy practices: You have the right to read our Notice Of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment payment activities, and healthcare operations, of the disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notices Of Privacy Practices. If we change our privacy practices, we will issue a revised notice Of Privacy Practices, which will contain changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Telephone: 303-765-2824

E-mail: drcarter@drcartersmiles.com

Address: 3955 E. Exposition Avenue, Suite 218, Denver, CO 80209

Right to Revoke: You will have the right to revoke this contract at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of the consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SECTION C: SIGNATURE

I, __________________________ have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature ____ **Date** ___________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to patient: ____

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General Dentistry Informed Consent

Patient Name ____

WORK TO BE DONE

I understand that I am having the following work done: Exam, cleaning, x-rays. (______) Initials

DRUGS AND MEDICATION

I understand that antibiotics, analgesic and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. (______) Initials

CHANGES IN TREATMENT PLANS

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. These changes could result in an increase in fees. I give my permission to the Dentist to make any/all changes and additions as necessary. (______) Initials

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. (______) Initials

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized. I am not under the treatment of any other dentist outside of the practice. (______) Initials

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay 40 to 50% above principal for any cost of collections that may be incurred to satisfy this obligation. (______) Initials

Signature of Patient ____ **Date** ______________

Signature of Doctor ____ **Date** ______________

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Consent to Share

I,______________________________________, give Dr. Colleen S. Carter and her staff permission to discuss all aspects of my treatment including but not limited to diagnosis, treatment plan, drugs administered, treatment outcomes, cost, insurance coverage and balance due with the following person(s) and their phone number(s):

1. ____
2. ____
3. ____

Your Personal Contact Information

I,______________________________________, give Dr. Colleen S. Carter and her staff permission to discuss all aspects of my treatment including but not limited to diagnosis, treatment plan, drugs administered, treatment outcomes, cost, insurance coverage and balance due by mail, voicemail, text and/or email on the listed address, phone number(s) and/or email(s):

Cell ____

Work ____

Home ____

Email ____

Address ____

____

Preferred method of contact? __________________________________

Signature of Patient ____

Date:____

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About Our Fees

We want you to feel comfortable with the dental care you receive, as well as our fees and payment arrangements. Please do not hesitate to discuss your treatment plan, fees or financial arrangements with us if you have any questions.

Payment Policy

Unless otherwise arranged before treatment, payment is expected at the time of service. There is a $75.00 charge for all returned checks. For your convenience, we accept Visa, MasterCard, American Express and Discover. ***A credit card convenience fee of 3.5% will be added to any total amount paid with a credit card. The convenience fee of 3.5% is discounted on any cash or check payments.*** Accounts outstanding more than 30 days from the date of treatment will bear interest at the rate of 1.75% per month or an Annual Percentage Rate of 21% per year. If this matter is assigned to a collection agency, you will be responsible for the collection charges and attorney's fees.

Insurance

We accept most insurance plans. We will work with you so that you will receive the maximum benefits you are entitled to from your insurance company. As a courtesy to you, we are pleased to promptly submit your dental claims to your insurance company. If your insurance company allows you to assign benefits, we will accept payment directly from the insurance company.

We do require, however, that you pay your portion of the co-payment at time of service. Please understand that although we will submit your claims for you, the responsibility for collection from your insurance company is ultimately yours.

Payment of any amount not covered by insurance is your responsibility. If your insurance claim is not paid by your insurance carrier within 60 days of the date of treatment, we require that you pay our office and have the insurance company reimburse you.

There will be a $250.00 fee for missed appointments without 48-hour business day notice. We value your time and the time you reserve is exclusively for you.

I have read the above, understand it, and agree to it.

Signature of Patient____ Date________________________

Patient Name (Printed):____

Office Representative: ____

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Cancellation Policy

We understand that unanticipated events happen occasionally in everyone's life, which will be taken into consideration for why you might consider rescheduling your appointment. However, you may have the opportunity to make up that visit before we close on Thursday of that week at no charge, if there is an appointment time available.

In our commitment to your health and creating a fair opportunity for other patients to schedule an appointment, we have adopted the following cancellation policy: **If you do not appear for your scheduled appointment, you will be charged a $250 fee that will automatically be charged to the credit card on record that will be securely stored.** We value your time and the time you reserve, is exclusively for you.

Please call the office at 303-765-2824 within two office business days for any appointment changes to avoid this fee.

I, (Print Name), ____________________________, consent to the above cancellation policy.

Credit Card Number: ____

Expiration Date: _________________ CVV: _________________________

Billing Zip Code: ____

Signature: ____

Date: ____