COLLEEN S. CARTER, D.D.S.

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

Date _____ Home Phone _____ Cell Phone _____

Patient Information

Name _____ SSN _____
Last Name First Name MI

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Married ❑ Single ❑ Widowed ❑Minor ❑ Partnered

Patient Employer/School _____ Occupation _____

Employer/School Address Employer Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name MI

Relation to Patient _____ Birthdate _____ SSN _____

Address _____ Phone _____

City _____ State _____ Zip _____

Insurance Company _____ Phone _____

Subscriber ID _____ Group Name _____ Group # _____

Additional Insurance

Subscriber Name _____ Birthdate _____ Relationship to patient _____

Address _____ Phone _____

City _____ State _____ Zip _____

Insurance Company _____ SSN _____

Subscriber ID _____ Group Name _____ Group # _____

Assignment And Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of insurance company

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 Of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of patient, Guardian, or Personal Representative Relationship

Colleen S. Carter, D.D.S
Health History
Confidential

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

Health History Continued
Confidential

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

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

COLLEEN S. CARTER, D.D.S.

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

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 Ave., 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: _____

COLLEEN S. CARTER, D.D.S.
3955 E. Exposition Avenue, Suite 218
Denver, CO 80209

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 and Discover.

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 fee for missed appointments without 2 business days notice. We value your time and the time you reserve is exclusively for you.

Working together
Our Patient Coordinator is available to answer your questions about fees, billing and financial arrangements. She is happy to respond your concerns regarding dental charges and will make every effort to arrange mutually satisfactory financial arrangements with you. Thank you.

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

Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

Dr. Carter Smiles
Colleen S. Carter, DDS, PC
Expect Excellence from your Dentist!

This document authorizes and instructs ***Dr. Carter Smiles*** to electronically process a $250 fee to my credit card account, indicated below, as a method of cancelling/missing a scheduled appointment without giving the mandatory 2 business days' notice. Please note this fee is non-refundable.

Credit Card Account Name:
Card Billing Address:
City, Province, Postal Code:

PRIMARY CARD:

Credit Card Type: Visa / MC / Discover	
Card Number (*enter number without spaces*):	
Expiration Date (MM/YY):	Security Code:

SECONDARY CARD:

Credit Card Type: Visa / MC / Discover	
Card Number (*enter number without spaces*):	
Expiration Date (MM/YY):	Security Code:

Signature:_____ Date:_____
(*Person authorized to sign for the credit card*)

My entry of the information above and my signature of this agreement shall be my authorization to electronically debit my credit card account indicated above. *If any debt is dishonored or returned for any reason I authorize an additional debit from the above account a $25 billing fee.*

COLLEEN S. CARTER, D.D.S.
3955 E. Exposition Avenue, Suite 218
Denver, CO 80209

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 24hours 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 _____

COLLEEN S. CARTER, D.D.S.
3955 E. Exposition Avenue, Suite 218
Denver, CO 80209

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):

1. _____
2. _____
3. _____

Personal Contact Information:

Cell _____

Work _____

Home _____

Email _____

Preferred method of contact? _____

Address _____

_____

Can we leave a detailed message/email on the numbers/email listed above? _____

COLLEEN S. CARTER, D.D.S.
3955 E. Exposition Avenue, Suite 218
Denver, CO 80209

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