Capstone Dental New Patient Registration

PATIENT INFORMATION

Patient Name Last _____ First _____ MI ___ Nickname _____
Residence Street_____ City _____ State_____ Zip _____
Mailing Address Street _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Mobile Phone _____
Sex: M / F Date of birth:_____ Married: Y / N email: _____
If student: Student status FT PT School _____ City/State _____ Zip _____
Employer_____ Occupation _____

Whom may we thank for referring you to our office: _____

SPOUSE/PARENT/GUARDIAN INFORMATION

Name Last _____ First _____ MI _____ Married: Y / N
Residence Street _____ City _____ State _____ Zip _____
Mailing Address Street _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Mobile Phone _____
Date of birth _____ Relationship to patient _____
Employer _____ Occupation _____

DENTAL INSURANCE (PRIMARY CARRIER)
Insured's Name _____
Insurance Company _____
Insured's Employer _____
Insured's Social Security # _____
Subscriber ID # if not SS# _____
Group Number _____
Insurance Co Phone Number _____

SECONDARY (Complete if you have dual coverage)
Insured's Name _____
Insurance Company _____
Insured's Employer _____
Insured's Social Security # _____
Subscriber ID # if not SS# _____
Group Number _____
Insurance Co Phone Number _____

MEDICAL HISTORY: This information will be kept confidential. Circle if any of these apply to you, now or in the past:
Heart Attack or Heart Disease / Angina / Murmur / Mitral Valve Prolapse / Rheumatic Fever / High Blood Pressure
Artificial Valve / Pacemaker / Artificial Joints / Diabetes / Anemia / Hemophilia / Bleeding Disorder / Ulcer
Blood Transfusion / Kidney Problems / Liver Problem / Thyroid disease / Hepatitis A, B or C / Glaucoma /Epilepsy
Seizures / Stroke / Tuberculosis (TB) / Asthma / Allergies / Chemo or Radiation Therapy / Arthritis / AIDS or HIV
Alcoholism / Drug Addiction / Psychiatric Treatment Do you smoke: Y / N

Are you allergic to or have you had any problems with the following:
Penicillin / Erythromycin / Codeine / Aspirin / Motrin or Advil / Local Anesthetic / Nitrous Oxide
If yes, Describe the problem _____
Allergy to other medications? _____
Current Medications: _____ Are you Pregnant: Y / N

Last Complete Dental Exam _____ X-Rays _____
Reason for your visit today _____
What would you change about your smile _____
Do you fear coming to the dentist Y / N If so, why? _____

Circle if you have had: Gum treatments / Bleeding gums / Problem with Jaw (TMJ) / Clenching
Grinding / Sensitivity / Denture / Partials / Braces / Implant / Periodontal Disease
How Often do you floss _____ Manual or electric toothbrush _____

_____

Patient Signature Date Doc Signature/Date

Capstone Dental PC

OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above $500.00, special financial arrangements may be discussed with our office manager.

- For patients with Dental Insurance:
  We will file your claim for you at *no charge*, however, we ask that your deductibles and your estimated portions (20-60%) be paid as services are rendered. Although we gladly file dental insurance claims, any and all account balances are ultimately your responsibility.

  Regardless of Insurance or Self Pay, should any outstanding balance remain unpaid, patients will be responsible for any collection fees, court costs, returned check fees and reasonable attorney fees associated with collecting any balance due Capstone Dental PC.

  All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.

- Please note for your convenience, we do accept VISA, MasterCard, Discover, American Express and Care Credit as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we would appreciate a 48-hour notice.** No Show/Late cancellation fees are as follows: 1st occurrence: no fee, 2nd occurrence: $50.00, 3rd occurrence: $100.00. 4th occurrence: dismissal from the practice.

- We realize that many families are in a state of change. **The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.**

- We will be fair in working out special finances with you, but please also be fair to us with your commitments. ***A 1.5% finance charge will be assessed monthly on all overdue balances.***

CONSENT:

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform diagnostic and treatment procedures, including local anesthesia, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date _____ Signature _____ (Patient, Parent or Guardian)

Capstone Dental Privacy Notice

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 303-805-3655.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Capstone Dental does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.
Capstone Dental maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Capstone Dental.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Capstone Dental occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

I, _____ have reviewed Capstone Dental PC Privacy Policy.

Signed: _____ Date: _____