AWESOME Dental

PATIENT INFORMATION – Please Print

Name: _____ Preferred Name_____

Date Of Birth:_____/_____/_____ Male Female Married Single Minor (Please check a box)

Social Security Number:_____ (For insurance billing purposes)

Home: _____ Cell: _____ Email: _____

Emergency Contact-Name: _____ Phone:_____

Preferred Contact: Email_____ Text__ _ Phone Call__ __ (Please check a box)

Address _____

City: _____ State: _____ Zip Code:_____

Who may we thank for referring you? _____

DENTAL INSURANCE INFORMATION

Insurance Carrier:_____ Phone Number:_____

Member ID:_____

(May be the subscriber SSN)

Group Name:_____ Group Number:_____

Subscriber Name:_____ Date Of Birth:_____/_____/_____

Relationship To Patient: Self Spouse Child_ _ Other (Please Check a Box)

SECONDARY DENTAL INSURANCE

Insurance Carrier: _____ Phone Number:_____

Member ID: _____

(May be the subscriber SSN)

Group Name:_____ Group Number:_____

Subscriber Name:_____ Date Of Birth:_ ____/_____/_____

Relationship To Patient: Self_ Spouse_ _ Child_____ Other___ (Please check a box)

We at Awesome Dental Colorado bill to your dental insurance company as a third billing party. It is the patient's responsibility to know their dental benefits. Initials: _____

COVID PRECAUTIONS

Have you experienced any OR a combination of fever, shortness of breath, congestion, coughing or sneezing in the last 5 days? YES☐ NO☐ (Please check a box)

Have you tested positive for COVID-19 (VARIENTS) in the recent past YES☐ NO☐ (Please check a box)

DENTAL HISTORY

Reason for today's visit _____

Approximate date of last dental visit _____ Date of last dental X-rays _____

Previous dentist _____

What did you like/dislike about your last dental visit? _____

MEDICAL HISTORY

Check if you have or have had any of the following

__ AIDS/HIV
__ Alcoholism
__ Allergies
__ Anemia
__ Anxiety Disorder
__ Artificial Joint(s)
__ Arthritis
__ Asthma
__ Autoimmune Disease
__ Bleeding Disorder
__ Blood Conditions
__ Bowel Disorder
__ Cancer
__ Depression
__ Diabetes
__ Eating Disorder
__ Epilepsy
__ Heart Disease
__ Heart Problems
__ Hepatitis
__ High Blood Pressure
__ High Cholesterol
__ Kidney Disorder
__ Liver Disorder
__ Lung Disease
__ Migraines
__ Osteoporosis
__ Pacemaker
__ Recreational Drug Use
__ Rheumatic Fever
__ Sinus Problems
__ Sexually Transmitted Disease (STD'S)
__ Stroke
__ Stomach Ulcer
__ Thyroid Disorder
__ Tobacco
__ Other
_____
_____

Currently taking any medication? If YES please list:

_____

_____

_____

Physician's Name: _____ Office Phone Number:_____
Date of last visit: _____/_____/_____

Have you had any serious illnesses or operations in the last six years? YES___ NO___(Please check a box)

If YES, please describe:

_____

_____

Any Allergies? YES___ NO___ (Please check a box)

If YES please list: _____

WOMEN: Are you pregnant: YES___ NO___ Nursing: YES___ NO:___ Taking birth control: YES:___ NO:___

AUTHORIZATION AND RELEASE

To the best of my knowledge, I certify the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, has had a change in health.

Signature: _____ Date:_____/_____/_____

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

FINANCIAL POLICY

PLEASE READ THE FOLLOWING:

- I am responsible for all charges on my account including charges not covered by my dental policy.
- **Payment is due at the time of service.**
- Awesome Dental Colorado accepts cash, checks and all major credit cards.
- Any outstanding balance must be paid to avoid cancellation of existing future appointments. Any account over 90 days may, at our discretion, be forwarded to a collection agency
- There will be a $25.00 fee for returned checks **(NSF).**

INSURANCE

Awesome Dental Colorado is contracted with most major PPO Dental Insurance policies as well as Colorado Medicaid. As a courtesy, we make every effort to verify eligibility and gather plan information before appointments. We at Awesome Dental Colorado bill to your dental insurance company as a third billing party. It is the patient's responsibility to know their dental benefits.

PLEASE READ THE FOLLOWING:

- If insurance coverage cannot be confirmed at the time of service I am responsible for payment in full.
- Services not covered or have reduced reimbursement(s) by my insurance will be my responsibility.
- I understand it is my responsibility to provide Awesome Dental Colorado with current dental insurance information as well as provide updates on any changes.
- Awesome Dental Colorado cannot guarantee payment from my dental insurance provider.
- I understand Awesome Dental Colorado provides **Estimates** of treatment costs (fees, deductible, co-payments, etc.) however **Estimates** may change depending on insurance guidelines.
- I may receive a balance due statement for any difference(s) once insurance payments have been made.
- I understand that my PPO dental plan contractually obligates Awesome Dental Colorado to follow their guidelines including **Fees charged for services provided**. NO discounts can be given consideration due to this legal arrangement
  .

INSURANCE AUTHORIZATION AND RELEASE

I certify that I, and/or my dependents(s), have insurance coverage with _____ and assign directly to Awesome Dental Colorado all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges paid or not paid by insurance and authorize the use of my signature on all dental insurance submissions.

Awesome Dental Colorado may use and disclose my health care information to the above named insurance company and their agents for the purpose of determining insurance benefits, obtaining payment for services or obtaining benefits payable for related services.

Signature _____ Date _____/_____/_____

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

AWESOME Dental

HIPPA NOTICE OF PRIVACY PRATICE ACKNOWLEDGMENT

I, _____, hereby acknowledge that I have read and understand
(Printed Name)
Awesome Dental Colorado's HIPAA Notice of Privacy Practices and/or have been given the opportunity to receive/read a copy of said practices.

I understand that Awesome Dental Colorado's HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of such revisions upon request. I understand if I have questions about Awesome Dental Colorado's HIPAA Notice of Privacy Practices,
I may contact Dr. David Hanna at (303) 355-1818.

I understand it is my right to refuse to sign this Acknowledgment should I so choose. I understand Awesome Dental Colorado will not refuse treatment if I refuse to sign this Acknowledgment. I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Awesome Dental Colorado's privacy policies and procedures.

_____ _____
Patient Signature Date

_____ _____
Print name of patients representative Signature of patient's representative

AWESOME Dental

Appointment Policy

We are happy you have chosen Awesome Dental Colorado as a partner in meeting your dental health needs. When you schedule an appointment at our office we reserve a specific time for you to be seen by our team at Awesome Dental Colorado. We spend time and energy preparing for your visit and anticipate that you will keep your scheduled appointment(s).

Changes to Appointment

We understand that plans change and that you may need to alter your scheduled appointment. We ask that you make every effort to give us the courtesy of **48 hours notice** to reschedule or cancel appointments. This courtesy will allow us to offer the appointment time to another patient in need.

We respect our patients' time and make every effort to remain on schedule. On occasion, we may run late with an appointment due to an unforeseen complication. If we are significantly delayed, every effort will be made to notify you beforehand so you may choose to come later or reschedule.

Late Arrival

Late arrivals can disrupt our schedule and inconvenience other patients as well as our staff. Please allow for travel time to our office and arrive at or before your scheduled appointment time. Your late arrival affects our ability to complete the scheduled treatment and doing so may result in your appointment being altered, delayed, or even rescheduled for a different day. A Missed Appointment Fee of **$75.00** will be applied.

MISSED APPOINTMENT FEE

A minimum charge of **$75.00** will be applied for all appointment changes made with in **LESS THEN 48 HOURS/NO-SHOWS.** This fee may also apply to late arrivals in the event we are unable to see the patient due to time constraints.

BY SIGNING BELOW, I ACKNOWLEDGE AND AGREE THAT I HAVE READ, UNDERSTAND, AND WILL COMPLY WITH THE APPOINTMENT POLICIES OF AWESOME DENTAL COLORADO LISTED ABOVE.

_____

SIGNATURE OF PATIENT/PRIMARY INSURED/LEGAL GUARDIAN DATE

_____

PRINTED NAME OF PATIENT