Alpine Dental

Chart

4000 Laramie st. • Cheyenne, WY 82001 (307)426-4014

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Who may we thank for referring you to this office?

_____

_____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Policy Holder Information.

This only needs to be completed if the insurance subscriber is someone other than the patient, or your are the parent/guardian of the patient.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Patient's relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insurance Company Phone Number:

_____

_____

Secondary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insurance Company Phone Number:

_____

_____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

What is your immediate concern?

_____

_____

Previous Dentist Name and Phone Number:

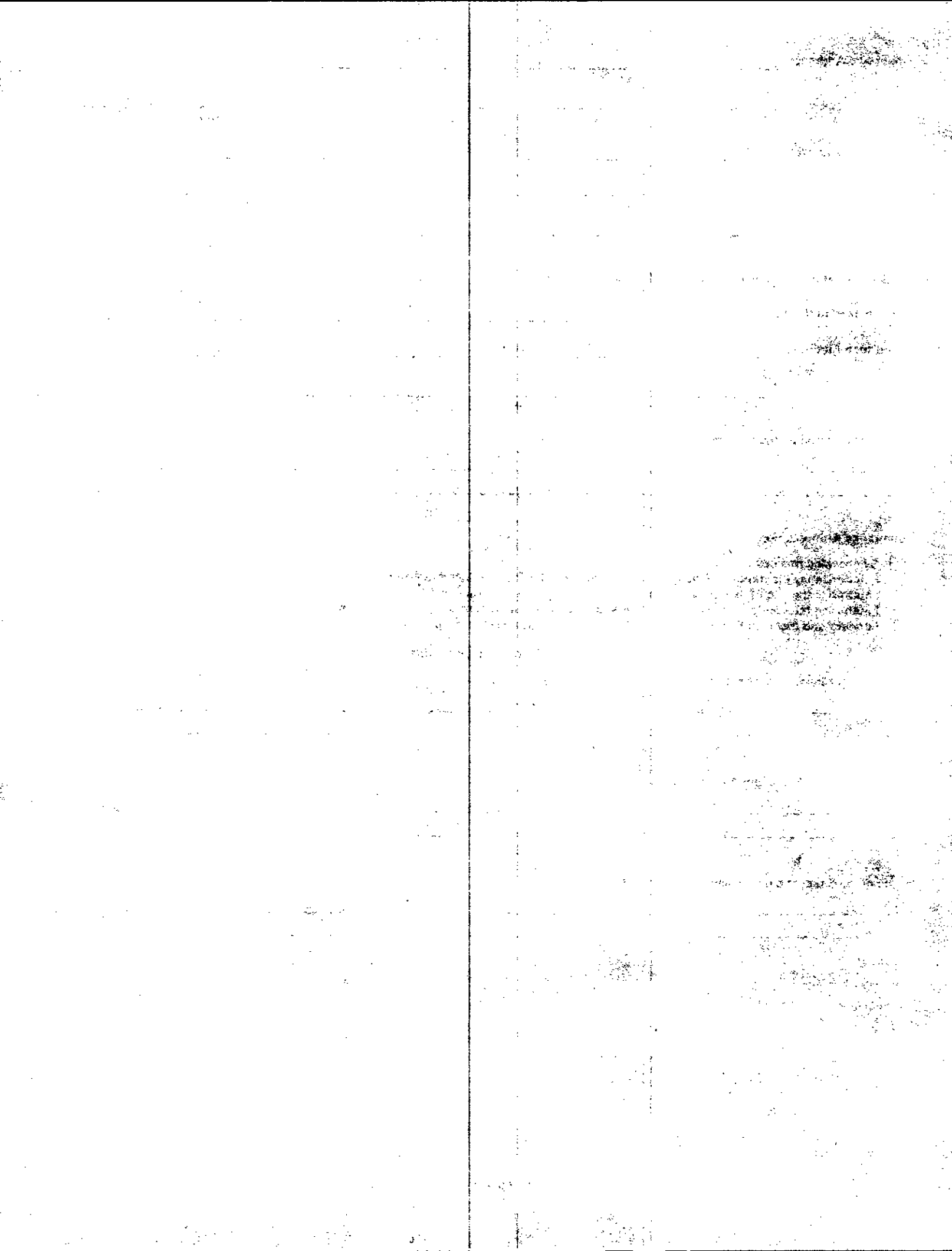
_____

_____

Date of most recent dental exam and dental x-rays:

_____

_____



Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment
- ☐ You experience dry mouth
- ☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Have you ever whitened or bleached your teeth
- ☐ Have you experienced popping and/or clicking of your jaw joint
- ☐ You have difficulty chewing
- ☐ You clench or grind your teeth
- ☐ You wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

Consent for Services and Financial Policy

Please read the following and initial in the space provided if you understand and agree to the following terms.

Payment

Patients that do not have dental insurance payment is required at time of service with no exceptions.

Patients that do have dental insurance the patient is responsible to pay the estimated portion according to their dental plan at the time of service with no exceptions.

Insurance Cards

Insurance cards are required when checking in for your appointment.

We will submit claims to your insurance to your insurance carrier as a courtesy. All non-covered charges are the patient's responsibility.

If incorrect insurance information is given or no update on changes of coverage a $5.00 charge may apply for resubmitting.

Late Policy

If you are 10 minutes late you will be asked to reschedule.

Missed Appointments

If you need to cancel your appointment please call 24 hours in advance. The first missed appointment, no action is taken. The second missed appointment, you will be charged a $55.00 cancellation fee. The third missed appointment, may result in dismissal from our practice.

I,,the undersigned, agree to pay for all services rendered to me immediately upon demand.

I further agree that in the event of non-payment of any amounts due under this agreement, I will pay interest thereon at the rate of 1.75% per month, and pay all reasonable attorney fees and court costs. I also agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due.

☐ *By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.

HIPAA Acknowledgement

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

The notice contains the patients' rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

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 health care 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 is 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.

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Name and Relationship to Patient:

_____

_____

☐ *By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

_____

Response Date: _____

Alpine Dental

Chart

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Medical History

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ ADHD
- ☐ Allergy - Other
- ☐ Allergy- lisinopril
- ☐ Asthma
- ☐ Chemo/Radiation
- ☐ Duloxetine
- ☐ HIV
- ☐ Heart Bypass
- ☐ High Blood Pressure
- ☐ Macrobid
- ☐ Pregnant
- ☐ Stroke
- ☐ alzheimers
- ☐ meperidine
- ☐ Acid Reflux
- ☐ Allergy - Penicillin
- ☐ Amiodarone
- ☐ Autism
- ☐ Deaf- hearing impair
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Mint
- ☐ STD/HPV
- ☐ Tobacco Use
- ☐ hydromorphone
- ☐ mini strokes
- ☐ Allergy - Codeine
- ☐ Allergy - Sulfa
- ☐ Anxiety
- ☐ Autoimmune Disease
- ☐ Diabetes
- ☐ Fainting
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Levaquin
- ☐ PTSD
- ☐ Seizures
- ☐ Tourettes
- ☐ hydroxyzine
- ☐ travatan z
- ☐ Allergy - Latex
- ☐ Allergy- Amoxicillian
- ☐ Artificial Joints
- ☐ Cancer
- ☐ Dimetap Cold & Flu
- ☐ Gabapentin
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Stomach Problems
- ☐ Tuberculosis
- ☐ lipitor

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

_____

_____

_____

_____

Allergies not listed:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ◯ Yes ◯ No

Pre-Med:

Emergency Contact Name, Phone, Relationship to Patient

Name of your Physician and Phone Number:

Preferred Pharmacy and Phone Number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

Are you currently taking any prescription medications. If yes, please list all medications and dosages below: * ◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

☐ *By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY

Please review and update the following information if needed. Thank you.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Response Date: _____