Welcome to Metropolitan Dental Care

Personal Information

Date_____
First Name_____Last Name_____Middle Initial_____
Preferred Name_____Address_____
City, State, Zip_____
Home Phone_____Work Phone_____Cell Phone_____
Male Female
Minor Single Married Domestic Partner
Birth Date_____Social Security #_____
Employer_____Occupation_____
E-mail Address_____
How do you prefer to be contacted? E-mail Phone
Who may we thank for referring you to our office? _____
Emergency Contact_____Phone_____

Responsible Party

Who is responsible for the account? _____
Name_____
Relationship to Patient_____Birth Date_____Driver's License #_____
Social Security #_____E-mail Address_____
Address_____
City,State,Zip_____
Employer_____Occupation_____
Method of Payment Cash Check Credit Card

Primary Insurance Information

Name of Insured _____Relationship to Patient_____
Insured's Birth Date_____Insured's Social Security #_____
Employer_____Date Employed_____Occupation_____
Insurance Company_____
Claims/Insurance Company Address_____
City, State, Zip_____
Group #_____Employee ID #_____
Deductible_____Maximum Annual Benefit_____Amount Used_____

Additional Dental Insurance

Name of Insured _____Relationship to Patient_____
Insured's Birth Date_____Insured's Social Security #_____
Employer_____Date Employed_____Occupation_____
Insurance Company_____
Claims/Insurance Company Address_____
City, State, Zip_____
Group #_____Employee ID #_____
Deductible_____Maximum Annual Benefit_____Amount Used_____

Consent:

I understand that responsibility for payment of dental services in this office for myself and my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees, and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance**. I also assign all benefits to the Dentist. I acknowledge that my signature on this document authorizes the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor.

Responsible Party's Signature_____Date_____

Dental History

Do you have or have you had any of the following?

Jaw/joint disorder
Injury to mouth/face
Tooth Removal
Orthodontic treatment/Braces
Bleeding gums
Periodontal surgery
Sensitivity to hot/cold/sweets/pressure

Nitrous Oxide Gas
Dental problems now_____
_____
Is there anything you wish you could change about your teeth?_____
Have you ever had an unpleasant dental experience?

Do you need to be pre-medicated with antibiotics before dental procedures (i.e. for congenital heart conditions) ? Yes No
Previous Dentist_____ Date of last dental visit_____
Why have you come to the dentist today?_____
How would you describe the condition of your teeth and gums? Good Fair Poor
Are you currently in pain or discomfort with your teeth and gums? Yes No
If yes, please explain: _____
If you could wave a magic wand and change anything you could about the appearance of your smile, what would you like to do?
_____
If you could easily and safely whiten your teeth, would you be interested? Yes No
How often do you brush your teeth? _____ Floss your teeth? _____
Do your gums bleed when you brush? Yes No Floss? Yes No
Have you ever experienced pain in your jaw joint? Yes No Do you grind your teeth? Yes No Do you snore? Yes No
Have you ever been treated for TMJ symptoms? Yes No If yes, please explain: _____

Medical History

Although dental personnel primarily treat the area in an around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now? Yes No If yes, please explain _____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain_____
Have you ever had a serious head or neck injury? Yes No If yes, please explain_____
Are you taking any medications, pills, or drugs? Yes No If yes, please explain_____
Do you take or have you taken Phen-Fen or Redux? Yes No
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No
Do you take or have you taken oral or I.V. bisphosphonates or any drugs for osteoporosis? Yes No

Women*:* Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other_____

Do you have or have you had any of the following?

AIDS/HIV positive	Congenital Heart Disorder	Heart Attack/Failure	Mitral Valve Prolapse	Tonsillitis	
Alzheimer's Disease	Convulsions	Heart Murmur	Pain in Jaw Joints	Tuberculosis	
Anaphylaxis	Cortisone Medicine	Heart Pace Maker	Parathyroid Disease	Tumors or Growths	Anemia
	Diabetes	Heart Trouble/Disease	Radiation Treatment	Ulcers	
Angina	Drug Addiction	Hemophilia	Recent Weight Loss/Gain	STD's	
Arthritis/Gout	Easily Winded	Hepatitis A	Renal Dialysis	Yellow Jaundice	
Artificial Heart Valve	Emphysema	Hepatitis B or C	Rheumatic Fever	High Cholesterol	
Artificial Joint	Epilepsy/Seizures	Herpes	Rheumatism	Osteoporosis	
Asthma	Excessive Bleeding	High Blood Pressure	Scarlet Fever	Eating Disorder	
Blood Disease	Excessive Thirst	Hives or Rash	Shingles	Prostate Issues	
Blood Transfusion	Fainting Spell/Dizziness	Hypoglycemia	Sickle Cell Disease	HPV	
Breathing Problem	Frequent Cough	Irregular Heartbeat	Sinus Trouble	Other not listed_____	
Bruise Easily	Frequent Diarrhea	Kidney Problems	Spina Bifida		
Cancer	Frequent Headaches	Leukemia	Stomach/Intestinal Disease		
Chemotherapy	Genital Herpes	Liver Disease	Stroke		
Chest Pains	Glaucoma	Low Blood Pressure	Swelling of Limbs		
Cold Sores/Fever Blisters	Hay Fever	Lung Disease	Thyroid Disease		

Physician Phone

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.
SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____DATE_____

METROPOLITAN DENTAL CARE P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect APRIL 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $ 50 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dawn White, D.D.S.

Telephone: 303-534-2626 Fax: 303-534-1802

E-mail:

Address: 1400 Glenarm Place, Suite 200 Denver Colorado 80202
