Buena Vista Dental Care

...Treating neighbors like family

115 Brookdale Ave • Buena Vista, CO 81211 • buenavistadentalcare.com • Phone: 719-395-2240 • Tuesday-Friday 8am-5pm

PATIENT INFORMATION

Patient Name:____ Birth Date:______________
Last First Middle Initial

Physical Address:________________________ City, State, Zip:______________________________

Mailing Address:________________________ City, State, Zip:______________________________

Cell Phone: __________________ Home Phone: __________________

Email Address:______________________________ Preferred Pharmacy:_____________________

SSN_______-_____-_______ Marital Status: ☐ Single ☐ Married Spouse's Name: ________________________

Employer:_________________________________ Work Phone:___________________________

Emergency Contact:_________________ Relationship to You:__________ Phone:__________________

If patient is a minor, list all legal guardians:____

FINANCIAL INFORMATION – REQUIRED

Who will be financially responsible for this account?____________________ Relationship to Patient ________

SSN for responsible party ______-_____-______ Name of Employer_________________________________

Best method(s) to contact you? ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Whom were you referred by? _________________________

FINANCING AND OFFICE POLICIES

DENTAL INSURANCE: Do you currently have dental insurance? ☐ Yes ☐ No (If yes, a dental insurance form must be on file)

FINANCING: Fees for treatment are to be paid at the completion of each appointment. We welcome the following forms of payment: Cash, Personal check (Colorado), MasterCard, Visa, and Discover. If you are unable to handle this by yourself, we recommend that you contact a commercial lending institution or ask about the Care Credit – Interest Free Payment Plan.

PROSTHETICS (CROWN, BRIDGEWORK, DENTURES, etc.): We require, in advance, half of the payment for the treatment in order to meet laboratory costs. The remaining balance is due when the prosthesis is delivered.

EMERGENCY TREATMENT IS ON A CASH BASIS ONLY.

APPOINTMENTS: Your appointments are scheduled to allow adequate time for your dental procedure; consequently, 48 hours notice is required for any appointment change or cancellation. If this request is not honored, or if you should fail to arrive for your appointment there will be a charge. *Office hours by appointment are Tues-Fri 8am-5pm.*

SUMMARY: We feel that a firm understanding of financial involvement is essential before beginning treatment in order to avoid possible misunderstanding and to assist you to plan accordingly.

I, the undersigned, have read and understand the above financial policies and will abide by them. I also authorize dental treatment to be rendered by the Dentist and his/her staff.

SIGNATURE ___________________________________ DATE ______________
Patient or Legally responsible party

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MEDICAL HISTORY

Are you currently under care of a physician? Y N (describe)____

Have you ever had a major surgery? Y N (list)____

Primary Physician:__________________________ Clinic:______________________________________

Do you have or have you ever had any of the following? Circle Y for Yes and N for No:

Y N Artificial Heart Valve
Y N Cardiac Transplant
Y N Congenital Heart Defect Repaired/Unrepaired
Y N History of Infective Endocarditis
Y N Artificial Joints Hip/Knee: what/when______________________
Y N Suppressed Immune System: reason______________________
Y N Heart Attack: year__________
Y N Stroke: year___________
Y N High Cholesterol
Y N Pacemaker
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Anemia
Y N Hemophilia, bleeding or blood disorder
Y N Blood Thinner(s): score of most recent INR_______
Y N Bruise Easily
Y N Epilepsy, Seizures
Y N Fainting Spells
Y N Vertigo
Y N Jaw Pain
Y N Frequent Headaches
Y N Osteoporosis
Y N Have ever taken Bisphosphonates (ex. Fosamax, Boniva)
Y N Autoimmune Disorder: Type______________________
Y N Diabetes or Hypoglycemia: Type I or Type II (circle)
Y N Chronic Sinus Problem

Y N Asthma
Y N Tuberculosis
Y N COPD or other Respiratory Disease
Y N Sleep Apnea
Y N CPAP
Y N Snoring
Y N Hepatitis: type_______
Y N Liver Disease
Y N Kidney Disease
Y N Thyroid Condition
Y N Ulcers
Y N Arthritis
Y N Depression
Y N Anxiety/Nervous Disorder
Y N Oral Herpes, Cold Sores
Y N Cancer: type___________________
Y N Radiation Treatment: year________
Y N Chemotherapy: year__________
Y N AIDS or HIV
Y N Eating Disorder: type_____________
Y N Chemical or Drug Dependency
Y N Tobacco Use: Current or Past (circle)
Type:___________________
Daily Amount:______________
Y N Pregnant: due date______________
Y N Using Oral Contraceptives

Allergies: ☐ **None** ☐ **Latex** ☐ **Penicillin** ☐ **Codeine** ☐ **Sulfa** ☐ **Local Anesthetic** ☐ **Other:**_______________

Y N Have you ever been advised not to take any medications? list_____________________________________

Medications:	For:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Notice of Privacy Practices & Consent for Use and Disclosure of Health Information: 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 our Privacy Officer using our office contact information.

Print Name:_________________________ Signature:______________________ Date:__________
Patient or Legally responsible party

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DENTAL HISTORY

Name:______________________________ Today's Date:____________________

Reason for today's visit:_____________________________

Date of last dental visit:___________ Date of last dental xrays:_____________

Name of previous dentist and/or clinic:___________________________

Are you presently in any dental pain? Y N describe:______________________________

Are you experiencing any of the following? Check all that apply

☐ Bad Breath ☐ Bleeding Gums ☐ Swollen/Tender Gums ☐ Unpleasant Taste in Mouth

☐ Previous recommendation or completion of Periodontal/Gum Treatment: date___________

☐ Sensitivity to Hot/Cold/Sweets (circle) ☐ Sensitivity to Pressure/Chewing

☐ Avoidance of Brushing Certain Areas ☐ Difficulty Swallowing ☐ Burning Sensation in Mouth

☐ Growths/Swellings in Head/Neck/Mouth (circle) ☐ Food Catches Often

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Have you experienced any unfavorable reactions to dentistry? Y N
describe____

What is your level of anxiety/stress/fear when going to the dentist? ☐None ☐Mild ☐Mod ☐Severe

Are you dissatisfied with your teeth and/or their appearance? Y N
describe:____

Are you deeply concerned about the finances required to return your mouth to excellent dental health? Y N

Have you lost any teeth besides your baby teeth? Y N

Have you had orthodontic treatment (braces)? Y N when:_______________________

Have you ever had a bad reaction to dental anesthetic? Y N describe:_____________________

Are you aware of or have you been told by a partner/spouse that any of the following applies to you?

☐ Clenching day/night (circle) ☐ Grinding day/night (circle) ☐ Snoring ☐ Breathing stops in sleep

☐ Jaw clicking/popping while eating or yawning ☐ Awaken with awareness in teeth or jaw

☐ Difficulty opening your mouth widely ☐ Stiff Neck Muscles ☐ Tension Headaches

☐ Pain/Soreness around eyes, ears, or other parts of your face ☐ Fatigued/sleepy during daytime

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We offer a variety of services to our patients. Is there any of the following services you would like to know more about? Please circle any of the following:

Dental Implants	Nothing replaces your natural teeth, but dental implants can come close.
Nightguards	Clenching/grinding causes chipping, wear and sensitivity. A nightguard prevents further damage.
Tooth Whitening	An effective way to brighten your smile.
Veneers or Crowns	Enhance the appearance of your smile with natural looking restorations.

BUENA VISTA DENTAL CARE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

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)

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<u>BUENA VISTA DENTAL CARE</u>

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 <u>April 14, 2003</u>, 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 dentist, 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. By state law, your authorization is valid for 90 days.

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 you 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 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 may charge you $0.83 for each page up to thirty (30) and $0.63 for each page after thirty, a $19 administrative fee to locate and copy your health information, and postage if you want the copies mailed to you. Radiographs (x-rays) will be duplicated at a reasonable fee. 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 a 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.

Privacy Officer: Ryan A. Mueller, D.M.D .

Telephone: (719) 395-2240 **Fax**: (719) 395-6272 **Email**: buenavistadentalcare@gmail.com

Address: PO BOX 4830, Buena Vista, CO 81211

IF YOU WOULD LIKE A COPY OF THIS NOTICE, PLEASE ASK US AND WE WILL BE HAPPY TO GIVE YOU ONE