Aspen Smile Dentistry, PLLC

Dr. Ian Lowell, D.D.S. & Dr. Jeremy Lowell, D.D.S.

Name: Last_____First_____Middle_____

Address:_____ City & State_____Zip_____

Phone: Home_____Work_____Cell_____

Social Security #_____Date of Birth_____ Sex: M or F

Email:_____ Status: Single / Married / Divorced / Widowed

Best way to contact you: Email/Home/Cell/Work Is it okay to leave voice mail on #'s provided? Y / N

If Child, Parent's or Legal Guardian's Name_____

Persons Responsible for this account _____D.O.B._____

Social Security # (if different from above)_____ In case of emergency who should we notify?_____Phone_____ How did you hear about our office? Mailer / Website / Referral from friend/family (name)_____

HEALTH HISTORY

Name of your Physician_____Phone_____Date of last physical_____

Please check any of the following that apply:

Heart	Blood	Respiratory	Intestinal	Bone/Joint	Other
__Chest pain __Shortness of breath __High Blood pressure __Low Blood pressure __Congenital Heart disease __Heart murmur __Heart valve problem __Heart Medication __Rheumatic Fever __Pacemaker __Artificial Heart __Heart attack	__Easy Bruising __Frequent nose bleeds __Abnormal bleeding __Anemia __HIV/AIDS __Hepatitis __Diabetes Type I Type II __Anticoagulants __Other:_____	__Asthma __Tuberculosis __Allergies What_____ _____ _____ _____ __Skin rash __Sinus Problems	__Liver Disease __Ulcers __Colitis __Weight Gain/Loss __Constipation __Jaundice __Kidney disease	__Joint replacement DATE:_____ __Arthritis __Bisphosphonates Use Med:_____ Date:_____ __Back/Neck pain __Pins/Metal rods	__Stroke __PTSD __ADD/ADHD __Seizure/Epilepsy __Fainting __Lightheaded __Glaucoma __Depression __Thyroid Disease __Cancer Type:_____ Radiation Y / N

Please list all **Prescription** medications_____

Please list all **Over the counter/Herbal supplements**_____

Any allergies to medications / Latex YES / NO

If yes, please list_____

Do you use tobacco? YES / NO If YES, what kind?_____

Do you use Marijuana or other recreational drugs YES / NO

If YES, please list:_____

DENTAL HISTORY

Last Dental visit?_____How often do you brush?_____Floss?_____

Are your teeth sensitive? NO / Sweets / Biting / Hot / Cold /

Other:_____

Do your gums bleed? YES / NO Last time you had a filling or other dental treatment_____

Do you clench or grind? YES / NO Do you have headaches? YES / NO if yes, how often?

_____

What qualities are you looking for in a dental home?

_____

WOMEN ONLY

Is there a possibility you could be pregnant? Y / N If yes, how many weeks?_____

Are you currently nursing? Y / N Do you use oral contraceptives Y / N list_____

Reservation Agreement

You are such an important part of our family and it deeply saddens us when you miss or cancel an appointment at the last second. It's much like being stood up at a wedding. We got all fancied up and pulled an all-nighter getting ready and planning. Now, Aunt Bertha is crying, cousin Tommy came all the way from Albuquerque, and apparently the florist has a "NO RETURN Policy." YIKES!!

So that we may try to serve others, all we ask is for a **48- hour advanced notice** (or Thursday if your appointment is on a Monday). Our last-minute cancellation/ no show fee is **$75/hour** that you were scheduled. We understand life gets busy sometimes, which is why you can contact us through any of these methods:

Email: info@aspensmiledentistry.com Phone: 970-925-6565 Website: www.aspensmiledentistry.com

I have read and agree to the above reservation statement. **Initial**:_____

General Consent/Dental Benefit & Insurance release

The information I have given today is correct to the best of my knowledge. **Initial**:_____
I have been advised of the **HIPAA** Privacy protection by this office. **Initial**:_____

I will hereby advise the office of any and all medical changes at each appointment. **Initial**:_____

I hereby authorize direct payment from my insurance company to Aspen Smile Dentistry and further authorize release of any and all information requested by the insurance company for processing my dental claims. **Initial**:_____

I am financially responsible for all charges, regardless of my insurance coverage. I also realize that it is my responsibility to be familiar with my insurance policy. Payment is due **AT TIME OF SERVICE**; if I have insurance, any and all co-payments and/or deductibles are due at the time of service. In accordance with the Federal Truth-In-Lending-Act, I realize that any balance over 60 days may be subject to a billing charge of $5 or 21%APR.
Initial:_____

IF I REFUSE TO PROVIDE MY SOCIAL SECURITY NUMBER, I agree to **PAY IN FULL** with credit card or cash at time of service, regardless of my insurance status. **Initials**:_____

I grant authority to the dentists and auxiliaries in charge of the care of the patient whose name appears on this form to perform dental and surgical procedures and treatments, including the administration of medicines and local anesthetics, that are deemed necessary and advisable for me as the patient. Patient and or legal guardian/parent will be informed before any treatment is performed.

I hereby certify the above to be true and correct to the best of my knowledge.

Authorized Signature_____Date_____

Dental Insurance ***(Seguro Dental)*** **YES** or **NO (*SÍ* o *NO*)**
If your answer is no, please do not fill out the rest of this section ***(Si su respuesta es no por favor no llene el resto de esta sección)***

Policy Holder's Name (*Titular de la Poliza*)_____

Employer Name & Phone (*Nombre y number de telefono del empleador*)_____

Insurance Company's Name *(Nombre de la compañía de seguros)* _____

Insurance Company Address (*Dirección de la compañía de seguros)*_____

Insurance Company Phone *(Número de teléfono de la compañía de seguros)*_____

Date of Birth of Insured Party (*Fecha de nacimiento del asegurado*) _____/_____/_____

Relationship to Patient *(Relación con el paciente)* _____

Group/Policy # (*Numero de Grupo/Poliza)*_____

Social Security Number *(Numero de Seguro Social)*_____

Secondary Dental Insurance ***(Seguro Dental Secundario)*** **YES** or **NO (*SÍ* o *NO*)**
If your answer is no, please do not fill out the rest of this section ***(Si su respuesta es no por favor no llene el resto de esta sección)***

Policy Holder's Name (*Titular de la Poliza*) _____

Employer Name & Phone (*Nombre y number de telefono del empleador*)_____

Insurance Company's Name *(Nombre de la compañía de seguros)* _____

Insurance Company Address (*Dirección de la compañía de seguros)*_____

Insurance Company Phone *(Número de teléfono de la compañía de seguros)*_____

Date of Birth of Insured Party (*Fecha de nacimiento del asegurado*) _____/_____/_____

Relationship to Patient *(Relación con el paciente)* _____

Group/Policy # (*Numero de Grupo/Poliza)*_____

Social Security Number *(Numero de Seguro Social)*_____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to disclose and use protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to this date I revoked this consent, is not in effect.