

WELCOME

Welcome to Primary Dental, we are pleased that you have chosen us for your dental needs.

OFFICE HOURS:

Monday – Wednesday	8 a.m – 5 p.m.
Thursday	8 a.m. – 6 p.m.
Friday (every other)	8 a.m. – 12 p.m.

APPOINTMENTS:

We will work with you to schedule appointments that are most convenient for you.

____We highly recommend that you schedule your next appointment before leaving the office. This will allow you to pick the day and time that suits you the best. As a courtesy we call one week prior to your appointment to remind you of the date and time. We will also call you the day before to confirm your appointment. So it is important for you to inform us if your phone number changes. This will allow us to keep your records current.

____We ask that you show up 10 minutes prior to your appointment to do any necessary updates. Showing up late for an appointment may result in cancellation or having to reschedule. Not attending your appointment without notifying us in advance is considered a broken appointment. This may cause a cancellation fee and difficulty scheduling future appointments. After two broken appointments, we will no longer be able to schedule an exact time for treatment. You will need to call at 8:00 or 1:00 to check for availability in that days schedule.

____Some appointments require a deposit: Larger, more comprehensive treatment plans scheduled for more than an hour require a **\$100 deposit**. This deposit goes toward the cost of treatment, but is non refundable if the appointment is cancelled or rescheduled without a 48 hour notice.

____If you need to reschedule/cancel an existing appointment, we ask for **24 hour notice** for an appointment of 1 hour or less. For appointments that are over 1 hour, we need **48 hour notice**. This will allow us to help other patients who are trying to get an appointment. If this policy is not followed, a **\$50 cancellation fee** will be charged to your account.

CHILDREN:

If your child needs to return for treatment, we ask that you please follow these instructions to help make your child's visit a positive one.

1. Give your child Motrin or Tylenol 1 hour prior to the appointment.
2. Keep a positive attitude, your child's attitude depends on yours. Stay positive and reassure them that everything will be ok. Remember if you are negative your child will be negative.
3. Make sure that your child is well rested for their appointment.
4. We ask that you make arrangements for other children that are not being treated. If you need to bring other children please bring things to entertain those children while your child is being treated.

In order for us to maintain the highest quality of service it is important that you follow these instructions.

PAYMENTS:

____We accept most major insurance plans and will file claims for you as a courtesy. However payment/co-pay is due at the time of service.

We accept Visa, MasterCard, *Care Credit** and Cash. **NO CHECKS**. Patients of record that are uninsured and pay with cash or credit card at time of service will receive a 20% discount.

____Remember we only quote estimates of what your insurance will reimburse and your out of pocket cost.

____**For Medicaid patients:** We are required to report all missed appointments to Medicaid. On the second violation, Medicaid may do a welfare check on your child. To avoid this, we strongly urge you to reschedule or cancel your dental appointments in the timely manner stated in our policy.

*Care Credit – A line of credit that offers NO INTEREST payment plans. There will be no interest assessed if the amount is paid within the promotional period. Otherwise interest is assessed from purchase date. Minimum monthly payments required. Subject to credit approval.

Please sign X _____

Primary Dental Patient Information

Please fill out this form completely

Patient Information

Patient's Name _____ Prefers to be Called _____ Date of Birth _____ M F

Address _____ City _____ State _____ Zip Code _____ Telephone Number _____

Medical History

Family Physician _____
Name _____ Address _____ City _____ Phone Number _____

Date of last physical exam _____ Findings? _____

Do you have an illness now? Yes No If yes, explain: _____

Have you ever been hospitalized? Yes No If yes, explain: _____

Are you presently under a physician's care? Yes No If yes, explain: _____

Allergic to any medication or allergic to anything else? _____ Type of reaction? _____

Taking any medication? Yes No If yes, explain: _____

If you are a female, are you currently pregnant? Yes No Maybe If yes, when is the due date? _____

Have you had any history of: (Circle those that apply)

Heart Murmurs	Blood Transfusions	Endocrine System Disorder	Liver Disease
Heart Trouble	Dates of Blood Transfusions: _____	Epilepsy	Lung Disease
AIDS	Breathing Problems	Eye or Sight Problems	Mental Retardation
Anemia	Congenital Birth Defects	Excessive Bleeding	Recurrent Headaches
Asthma	Convulsions/Seizures	Hearing Problems	Rheumatic Fever
Bacterial or Viral Infection	Diabetes	Jaundice	Speech Impediment
Behavioral Problems	Digestive System Disorders	Kidney Problems	TMJ Problems
Blood Disease	Emotional Problem	Learning Problems	Tumors/Cancer
Others (please list) _____			

Is there anything else that we should know about your medical history? _____

Dental History

Is this your first dental visit? Yes No _____

Previous Dentist _____ City _____ Date of Last Visit _____ X-Rays _____

What is the reason that you are here for dental care? _____

Is there now or has there ever been any of the following? (Please circle)

Cavities	Toothache	Pain	Broken Tooth
Extracted Teeth	Straightened Teeth	Gum Infection	Mouth Injuries

Has patient had a history of: (Please circle)

Thumb Sucking	Finger Sucking	Teeth Grinding
Nail Biting	Smoking	

Have you ever had an unfavorable medical or dental experience? Yes No

If yes, please explain: _____

Do you brush regularly? Yes No Do you use dental floss? Yes No Sometimes

Responsible Party

Name

Emergency contact (Name)

Address

Address

City State Zip

City State Zip

Social Security Number Birthdate

Home Phone # Cell/Alt Phone#

Home Phone # Cell/Alt Phone #

Employer Work Phone #

Insurance Information

Insurance Company (Primary) Phone # Group #/ID #

Insured Person's Name SS # Birthdate

Address (if different from patient) City State Zip Phone #

Insurance Company (Secondary) Phone # Group #/ID #

Insured Person's Name SS # Birthdate

Address (if different from patient) City State Zip Phone #

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. If my account requires servicing by a collection agency or by an attorney I understand that I will be liable for the collection fees, attorney fees, applicable court costs and a monthly finance charge of 1.5% (18% annually) will be assessed on remaining balance. I also request that payment under my dental insurance program be made directly to Primary Dental on any unpaid bills for services furnished by me or my family. I authorize the release of any dental information necessary to process this claim and all future claims.

Patient Initial _____

I understand that Primary Dental requests a 48 hour notice prior to a cancellation of any appointment. I understand there is a \$50 cancellation fee if cancelled with out notice. After three appointments that are cancelled without a 48 hour notice, I understand that Primary Dental will no longer be able to see me. I understand that doctors Chad Williamson and Les Maes are general dentists. If you have any concerns about this, please feel free to discuss it with the doctors.

Patient Initial _____

Signature Date

Reviewed By: Doctor Date

Primary Dental

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: TO THE PATIENT/PARENT/GUARDIAN---PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent our use and disclosure of you protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting any one of our staff members at:

Primary Dental
5801 w 44th Ave. Suite D-160
Denver, Co. 80212
Telephone #: 303-433-1239 or Fax# 303-455-5317

SECTION B: PATIENT GIVING CONSENT

Patient name: _____

Date of Birth : _____

Right to revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the office listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and we may decline to treat you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

Signature: _____ **Date:** _____

Printed name: _____

Relationship to Patient _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
