Patient Information

Name _____ Date of Birth _____
Address _____ City _____
State _____ Zipcode _____ Apt. #____ Home Phone _____
Sex □ Male □ Female Cell Phone _____
E-mail (opt.) _____
Social Security (for insurance) _____
How did you hear about us? _____

Responsible Party Information *only fill out if different from above*

Name _____ Relationship to patient _____
Address _____ Date of Birth _____
City _____ State _____ Zipcode _____ Apt.#____
Home phone _____ Cell phone _____
Social Security (for insurance) _____

Insurance Information *If the same as above leave blank*

Please provide insurance card

Policy Holder's Name _____ Holder's Date of Birth _____
Holder's Employer _____ Holder's Social Security _____
Insurance Company _____ ID # _____
Insurance Company Mailing Address _____
_____
Group # _____

Secondary Insurance Information

Policy Holder's Name _____ Holder's Date of Birth _____
Holder's Employer _____ Holder's Social Security _____
Insurance Company _____ ID # _____
Mailing Address _____
Group # _____

We accept Visa, Discover, MasterCard, American Express, cash, or checks.
Please understand any part not covered by insurance is your responsibility.

Are you having pain or discomfort at this time?	Yes	No
Do you feel very nervous about having dentistry and dental treatment?	Yes	No
Have you been hospitalized in the last two years?	Yes	No
Have you been under the care of a physician in the last two years?	Yes	No
Have you been taking prescription medicine in the last two years?	Yes	No
Do you have any drug allergies? PLEASE LIST BELOW	Yes	No
Do any medications cause other problems for you?	Yes	No
Do you have any bleeding problems?	Yes	No
Did you read this question?	Yes	No
Women--- are you pregnant or planning a pregnancy?	Yes	No

Health History

Please circle any of the following which you have had in the past or currently apply.

Heart problems Rheumatic fever Heart murmur or artificial valve
Asthma Liver disease Infectious diseases such as TB, Hepatitis, HIV, other
Bleeding disorders Diabetes (Please explain "Other"_____)
Anemia Thyroid issues Cortisone or steroid medications
Ulcers Fainting/Dizziness Kidney disease or failure
Allergies (Please list): Seasonal _____
_____

What medications do you take? _____
_____
_____

Please list any disease, condition, or problem not mentioned above. _____
_____
_____
_____

HIPAA Consent

Highland Meadows Dental Health Center requests your consent to use and disclose your private health information when needed to facilitate your care and payment**. This consent allows us to provide services such as consultation with other health professionals involved in your care, send statements to your insurance company, and to leave messages with family members regarding appointments.** Often times other instances will occur where we will need to use your private health information. This is not consent to release of your personal information for advertising purposes or other reasons not related to your dental / medical care.

You may revoke this consent at any time. To do so please provide us with a written notice informing us of any restrictions or desire to revoke all consent. Please sign and date the request.

Please ask our personnel if you would like to review our privacy policy.

_____

Signature – Self / Parent / Guardian Date

Highland Meadows Dental Health Center, LLC
8201 Spinnaker Bay Dr. Suite A
Windsor, CO 80528

Phone 970 226 4098 Fax 970 226 4791

Office Policy Addendum - Patient Responsibilities & Office Policies

1) **Payment for your care or your estimated portion is due at the time of service.**
2) Please provide 24-48 business hours notice if you must miss an appointment, **and please remember that reminder phone calls / postcards are a courtesy. Without appropriate cancellation time, we expect patients to honor their appointments.**
3) Your appointment time is the time we expect to seat you, please arrive on time and remember that our office opens at 9am and our lunch hour is from 1pm-2pm.
4) **Missed appointments may be assessed a missed appointment fee of $10.00.**
5) I request HMDHC to bill my insurance as a courtesy, and consent to payment being made directly to HMDHC from my insurance company.
6) I understand the fee requested at the time of service is an **estimate** of the patient portion due.
7) **If you have a disagreement with the insurance portion, we will try to assist you, but ultimately your insurance coverage is a contract between you and the insurance company**. ***Any remaining balance after 90 days is patient responsibility.***
8) I understand that I am the responsible party for payment of all treatment provided. I authorize Highland Meadows Dental Health Center to speak with 3rd parties as needed to obtain payment.
9) Please turn off cell phones or other electrical devices while in the office.
10) Do not leave unattended children in the waiting area.
11) **Do not leave the property if your dependant is receiving treatment.**
12) Only one family member may accompany a patient in the treatment rooms.
13) I understand that if I or the person I am responsible for presents a need for care, I am:
    - Agreeing to a service and this service **does** have an associated fee I am responsible for.
    - Consenting to a treatment plan and the possibility of alternative treatment options.

I have read and understand all the above statements. To the best of my knowledge, all of the preceding answers are true and correct. **If I ever have any changes (health, medicine, address, etc.), I will inform Highland Meadows Dental Health Center at the next appointment.**

Signature – Self / Parent / Guardian **Date**