We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.
Thank you!

Today's date: _____

ABOUT YOU

Name: _____ o Female o Male

Preferred To Be Called: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Ext: _____ Preferred: _____

Birth date: _____/_____/_____ Social security number: _____

E-mail address: _____

Employer: _____

Present position: _____

Marital status: o Single o Married o Widowed o Divorced

Name of spouse: _____

Spouse's birth date: _____/_____/_____ Spouse's SS#: _____

Spouse's employer: _____

Whom may we thank for referring you? _____

Names of children: _____

How do you enjoy spending your free time? _____

EMERGENCY INFORMATION

Person to contact: _____ Relationship: _____

Phone: _____

Address: _____

INSURANCE INFORMATION

Insurance Co.: _____ Ins Ph #: _____

Subscriber Name: _____ Relationship: _____

Subscriber ID: _____ Subscriber birth date: _____

4185 E. Wildcat Reserve Pkwy. Ste 300, Highlands Ranch, CO 80126 Phone 303-683-2300 Fax 303-346-8014

DENTAL & MEDICAL HISTORY

Previous dentist's name: _____ When was your last dental visit? _____
Do you have any dental anxieties? o Yes o No If yes, please explain:
_____
If you could wave a magic wand, and change anything about the appearance of your smile, what would it be?
_____
Name of personal physician: _____
Address: _____Phone number: _____
Approximate date of last visit: _____Current health condition: o Excellent o Good o Fair o Poor
Have you had any serious health problems in the last five years? o Yes o No
If yes, please explain: _____
(For women) Are your currently pregnant? o Yes o No If yes, how many months?_____
Do you take St. John's Wart? o Yes o No Do you take any vitamin/herbal supplement? o Yes o No
If yes, which: _____
Are you taking any prescription medications? o Yes o No
Please list: (Name of medication) _____
Chew tobacco or smoke? o Yes o No Consume alcohol daily? o Yes o No
Do you regularly drink grapefruit juice? o Yes o No

Please check if you're allergic to OR have had any adverse reactions to any of the following:

- ☐ Local anesthetics
- ☐ Penicillin/Amoxicillin
- ☐ Other antibiotics_____
- ☐ Shellfish, iodine or red wine
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Barbiturates, sedatives, sleeping pills
- ☐ Other_____
- ☐ Codeine/other narcotics
- ☐ Latex sensitivity

Do you have, or have you had, any of the following? Please Circle

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? If yes, please explain: _____

The information I have given is true and accurate to the best of my knowledge

Signature _____ *Date* _____

4185 E. Wildcat Reserve Pkwy. Ste 300, Highlands Ranch, CO 80126 Phone 303-683-2300 Fax 303-346-8014

OFFICE FINANCIAL POLICY

In order to run our office in an efficient, effective manner, we have developed some policies for the management of our patient's financial responsibilities. Please take a few minutes to familiarize yourself with our guidelines. We encourage your questions and comments.

APPOINTMENT POLICY

We see all patients on an appointment basis, doing our best to see all patients on time. We request that you arrive promptly for the time we have reserved for you. If, for any reason, you need to make changes to your appointment, we require a **2 business days notice** during business hours, so this time may be offered to another patient. We do understand that unforeseen circumstances arise. In the event that we do not receive 48 hours notice prior to a scheduled appointment or an appointment is missed for any reason without notifying our office, we reserve the right to charge a cancellation fee of **$50.00 per hour. For example: This means you will be charged $150 for a three hour appointment.** **Initials** _____

PAYMENT OF FEES FOR NON-INSURED PATIENTS OR PATIENT COPAYS

Payment is due the day service is rendered in all instances, unless other arrangements have been made in advance. We accept cash, check, MasterCard, Visa, American Express, and Discover. Please feel free to take advantage of your charge card for you visits. We also offer no interest payment plans thorugh CareCredit Financing. This is a convenient, low minimum monthly payment program for your entire family specially designed to pay for healthcare and elective treatment not covered by insurance. This allows you the option of paying the full amount with a single easy payment to us and you can spread your payments through your charge card over an extended period interest free. **Initials** _____

PATIENTS WITH DENTAL INSURANCE COVERAGE

Payment of your estimated portion of your treatment is due the day service is rendered. Dental insurance is designed to assist patients with their dental needs. It is not intended to be for complete coverage for all treatment. Not all plans are the same. The extent of your benefits depends on the quality of the plan purchased by your employer. If your employer has purchased a good plan, you will have good benefits. If your employer has purchased a limited plan, then you will have restricted coverage. Please keep in mind that we have no control over the coverage purchased by your employer. We can attempt to find out your maximum and your deductible, but it is ultimately your responsibility to become familiar with your own plan. Our services and our fees are based on your dental health needs and have nothing to do with your insurance. We are more than happy to submit your dental claim form to your carrier so that you may receive maximum coverage under your plan. **Initials** _____

SOME GENERAL INSURANCE GUIDELINES

Please be sure to know your insurance company's name, address for claims, phone number, and group number. To accurately check your insurance benefits and file your claims we will need your personal identification number or social security number, whichever applies to your specific insurance plan. Please be sure to advise us if this information changes at any time throughout the year, so that we can update our records.

You are ultimately responsible for the entire fee regardless of the portion covered by your insurance. Insurance coverage usually ranges from 50% to 90% of the treatment fees. We will do our best to present you with a treatment plan estimate; however, it is only an estimate and not a guarantee of payment by your insurance company.

We will do our best to collect payment from your insurance company. **If a claim is denied, downgraded, or uncollectible for any reason, any portion not paid by your insurance company will be your financial responsibility. Initials** _____

CONSENT FOR TREATMENT AND INSURANCE INFORMATION RELEASE

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to diagnose my dental needs. Upon diagnosis, I hereby authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. This treatment may require the use of anesthetics, sedatives, and other medications as necessary. I understand that I can ask for a complete recital of any possible complications. I understand that Redfearn Family dental utilizes Expanded Duties Dental Assistants (EDDAs), whom have gone through additional training and certification, to do restorative work. **Initials** _____

I authorize the provider and staff to release any information required to process insurance claims. I understand that any portion not paid by my insurance company will be my financial responsibility. **There will be a 1 1/2 % per month (18% per year) finance charge on balances unpaid after 60 days. Insurance and patient portions are estimates provided as a courtesy. In the event that your insurance carrier pays less than the estimated amount, you are responsible for the unpaid balance. Initials** _____

If my account is not paid within 90 days of the date of service and no financial arrangements have been made, I understand that I will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting on my account. **Initials** _____

We welcome you to our office and look forward to helping you achieve the healthy, beautiful smile you deserve.

Please print patient's name _____

Patient/Guardian Signature _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail_____

Patient Number: _____ Social Security Number_____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of consent: By signing this form, you will consent to our use and disclosure of your 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 your 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:

Contact Person:	Trent R. Redfearn, DDS
Telephone:	303-683-2300
Fax:	303-346-8014
E-Mail:	
Address:	4185 Wildcat Reserve Pkwy., Suite 300, Highlands Ranch, CO 80126

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person 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 that we may decline to treat you or to continue treating 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 operations.

Signature: _____Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

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

Include completed consent in the patient's chart.