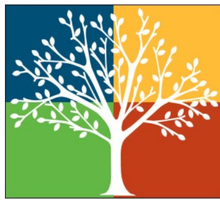


All Seasons Dental, Inc.
2208 Thatcher Ave
Pueblo, CO 81004
(719) 545-3838
allseasonsdentalco.com

Patient Information

Welcome to All Seasons Dental! We appreciate you choosing to let us serve you. To assist us in providing you quality service, please complete the following form. The information you provide us will remain strictly confidential. If you have any questions, please don't hesitate to ask!

General Information

Patient name: ______________________________ Date of Birth: ____________

Social Security Number: ______________________ Employer: ________________

Home address: ____

City: ______________________ State: _____ Zip: ________

Billing Address: ____

City: ______________________ State: _____ Zip: ________

Home Phone: (____) ____________ Best Time of Day to Call: ________ am or pm

Cell Phone: (____) ____________ Best Number to Call: (Circle one)

Work Phone: (____) ____________ Home Cell Work

Email Address: ____

Name of Medical Doctor: ______________________ Date of Last Visit: __________

Reason for Last Visit: _____________________________________

Name of Previous Dentist: ____________________ Date of Last Visit: __________

Reason for Last Visit: _____________________________________

Dental Insurance Information

Primary Dental Insurance: ______________________ Group #: ____________

Subscriber's Name: __________________________ Date of Birth: __________

Subscriber #: ____________ Employer: __________________________

Secondary Dental Insurance: ____________________ Group #: ____________

Subscriber's Name: __________________________ Date of Birth: __________

Subscriber #: ____________ Employer: __________________________

Other Information

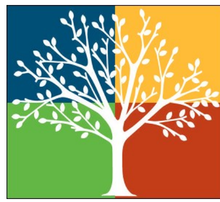
How did you find out about us? (Please circle one)

Dental Insurance List Friend /Family Member Online Search Engine

Newspaper Ad Other

If friend/family or other, please tell us who we can thank for referring you to our office: ____________

____



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Medical History

Do you have any of the following?

	Yes	No
Heart Problems		
Chest Pain /Angina	☐	☐
High Blood Pressure	☐	☐
Heart Murmur	☐	☐
Heart Valve Problem	☐	☐
Artificial Heart Valve	☐	☐
Rheumatic Fever	☐	☐
Pacemaker	☐	☐
Breathing Problems		
Shortness of Breath	☐	☐
Persistent Cough	☐	☐
Asthma	☐	☐
Bronchitis/COPD	☐	☐
Difficulty Breathing	☐	☐
Tuberculosis	☐	☐
Bleeding Problems		
Bruise Easily	☐	☐
Frequent Nose Bleeds	☐	☐
Blood Clots	☐	☐
Ever Received a Transfusion	☐	☐
Intestinal Problems		
Ulcers	☐	☐
Gastric Reflux (GERD)	☐	☐
Frequent Heartburn	☐	☐
Irritable Bowel	☐	☐
Neurologic Disorders		
Epilepsy	☐	☐
Seizures	☐	☐
Autoimmune Diseases		
HIV/AIDS	☐	☐
Hepatitis Type _______________	☐	☐

	Yes	No
Liver or Kidney Disorders		
Jaundice	☐	☐
Hepatitis	☐	☐
Problems Urinating	☐	☐
Lupus	☐	☐
Bone or Joint Problems		
Arthritis	☐	☐
Back or Neck Pain	☐	☐
Joint Replacement Surgery	☐	☐
Joint ___________ Date ___________ Right or Left		
Endocrine Disorders		
Diabetes	☐	☐
Excessive Thirst	☐	☐
Thyroid Disorder	☐	☐
Cancer or Tumor		
Diagnosed with cancer	☐	☐
Chemotherapy	☐	☐
Radiation	☐	☐
Surgery to Remove Tumor	☐	☐
Allergies		
Hay Fever	☐	☐
Skin Rashes	☐	☐
Latex	☐	☐
Metals	☐	☐
Local Anesthetics (Novocaine)	☐	☐
Penicillin	☐	☐
Sulfa Drugs	☐	☐
Aspirin or Ibuprofen	☐	☐
Narcotic Pain Medications	☐	☐
Other Medications Allergies	☐	☐
______________________________________		

Women:

	Yes	No
Are you pregnant?	☐	☐
Trying to become pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking contraceptives?	☐	☐
Are you taking hormones?	☐	☐

Medications: **(Please list all medications you are currently taking. If you need more room, use the back of this page.)**

____

____

____

____

Patient/Parent Signature: ______________________________ **Date:** _______________

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Dental History

What brings you to our office today? ____________________

Are you satisfied with the appearance or function of your teeth? (Circle One) Yes No

If no, what would you change? ____________________

____

____

How often do you brush? ____________ How often do you floss? ____________

Is it important to you to:

	Yes	No
Keep your teeth?	☐	☐
Improve the appearance of your teeth?	☐	☐
Improve the function of your teeth?	☐	☐
Have flexible scheduling options?	☐	☐
Make monthly payments?	☐	☐

Have you noticed any of the following:

	Yes	No
Food catching between your teeth?	☐	☐
Gums bleeding after brushing?	☐	☐
Loosening of your teeth?	☐	☐
Sensitivity in your teeth?	☐	☐
Pain associated with a tooth?	☐	☐
Pain when eating or drinking?	☐	☐
Swelling?	☐	☐
A broken tooth?	☐	☐
Pain in your jaw joint(s)?	☐	☐
Clicking or popping of your jaw?	☐	☐
Clenching or grinding?	☐	☐
Unusual bumps in your mouth?	☐	☐

Have you ever had problems with dental treatment? Yes ☐ No ☐

If yes, please describe: ____________________

____

____

____

Are you apprehensive about dental treatment? Yes ☐ No ☐

If yes, please tell us what we can do to help ease your anxiety: ____________________

____

____

____

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HIPPA – Notice of Privacy Practice

HIPPA is a federal law developed to provide a standard for the protection of your health information. The purpose of this Notice of Privacy Practice is to explain how All Seasons Dental, Inc. may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations.

Though All Seasons Dental, Inc. has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgment that you have received the Notice. I understand that by signing this consent I authorize All Seasons Dental, Inc. to use and disclose my protected health information to carry out:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers such as my insurance company.
- Conduct normal dental healthcare operation.

I have received, read and understand your Notice Of Privacy Practices containing a more complete description of uses and disclosures of my health information. I understand that All Seasons Dental, Inc. has the right to change its Notice Of Privacy Practices from time to time and that I may Contact this organization at any time at the address above to obtain a current copy of the Notice Of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand All Seasons Dental is not required to agree to my requested restrictions, but if they do agree then they are bound to abide by such restrictions. Under this law, All Seasons Dental, Inc. has the right to refuse to treat me, should I choose to refuse to disclose my Personal Health Information or if the restrictions I request will prevent adequate treatment or undue hardship on the practice.

If you have any questions, please contact our HIPAA Compliance Officer: Mary Aguilar.

I hereby acknowledge that I have received a copy of All Seasons Dental, Inc. Notice of Privacy Practices.

Patient/Parent/Guardian Signature: ____ **Date:** ____________________

Permission to Bill Your Insurance

All services rendered are the responsibility of the patient. As a courtesy to you, All Seasons Dental, Inc. will file the necessary forms with your insurance carrier.

I understand my signature authorizes the release of my medical/dental information to my dental insurance company in order to facilitate their payment for services rendered. I also recognize I will be responsible for payment of all charges in full if I do not authorize All Seasons Dental, Inc. to release my protected medical/dental information to my insurance carrier.

Patient/Parent/Guardian Signature: ______________________________________ **Date:** ____________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices of All Seasons Dental, Inc. but was unable to do so because:

☐ Individual refused to sign.

☐ A communication barrier prohibited obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Other (Please specify): ____

Signature of Office Staff: ____ **Date:** ____________________

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Financial Policy

Thank you for choosing All Seasons Dental for your dental needs. We are committed to providing you with excellent care and exceptional customer service. Our convenient financial arrangements are based on an open discussion of recommended treatment options, respective fees and your financial capabilities. Because we value you as a patient, we have worked diligently to find financial options that are rarely found at other dental offices. This Financial Policy is indicative of our respect for your right to know ahead of time what our expectations are of you in the area of finances.

Payment

Payment in full is due at the time of service unless prior financial arrangements have been made. We offer several payment options:

- Cash, Check, Visa, MasterCard or Discover card payments can be made at the time services are rendered.
- Monthly payment plans are available but may require a down payment, initiation fee and/or interest charges.

Insurance

The dental insurance contract is between you (the patient) and your insurance company. Therefore, you are responsible for the bill, regardless of the insurance coverage. As a courtesy to you, we will bill your insurance company; however, the responsibility for payment remains with you. Because insurance policies vary greatly, we can only estimate your coverage in good faith, but cannot guarantee it. In order for us to bill your insurance, you must supply our office with complete information about your coverage including, but not limited to, company name, employer and insurance group number. Insured dental patients are expected to pay the estimated non-insurance portion at the time of service as described above in the “Payment” section.

Payments and Billing

If your insurance has not paid within 60 days of treatment, you will be responsible for payment of the insurance balance. You will be reimbursed promptly if/when the insurance company remits payment to us unless you have an outstanding balance with our office in which case your unpaid portion will be subtracted from the total prior to issuance of the refund.

We mail monthly statements to all patients with an outstanding balance. Patients will be responsible for a $5.00 billing fee for any statement sent. Unpaid balances over 60 days will be assessed a finance charge of 18% per annum. In the rare instance an account with an unpaid balance becomes past due 90 days, the account will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt.

Missed or Failed Appointment Policy

All Seasons Dental is careful in scheduling every appointment so that each patient receives their recommended treatment in a reasonable amount of time. In order to consistently provide this type of care, it is important for you to be on time for your appointments so we can keep our schedule running smoothly. Late or broken appointments prevent others from receiving the dental care they deserve. We understand that emergencies happen but we take missed appointments very seriously. We ask that you be considerate and inform us as quickly as possible if you need to change your appointment. When an appointment is cancelled with less than 48 hours notice or if the appointment is not honored, you may be charged a $50 missed appointment fee. If three appointments are cancelled without sufficient notice or are missed, you may be dismissed from the practice. If you move or change phone numbers and do not inform our office, we may be unable to contact you in order to confirm your appointment. In such an instance, your appointment time will not be held for you.

Treatment of Minors

Consent for treatment by a parent of legal guardian is required when treating a minor child. In some cases, you can sign a consent form for us to keep on file. This is helpful when the patient is over 16 and is a licenses driver. All Seasons Dental retains the right to refuse to treat a minor child if the proper consenting adult is not present for the dental appointment. We also require that the adult remain on the premises during the entire treatment. In the case of divorce or separation, the parent authorizing treatment for the child(ren) will be the parent responsible for that day’s charges. We do not get involved with divorce specifics. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the parent’s obligation to work out an agreement themselves or through the court system.

By signing below, I acknowledge I have read and understand the “Financial Polices” of All Seasons Dental. I also acknowledge having had the opportunity to have my questions about these policies answered prior to signing.

Patient/Parent Signature: ______________________________ **Date:** ________________