204 E. Baseline Rd.
Lafayette, CO 80026
303-665-4000
www.DentistLafayette.com

Patient Information

Patient's Name _____ Preferred Name: _____

Birthdate: _____ Age: _____ Social Security # _____

Parent/Guardian's Name _____

How did you hear about our office:
☐Friend/Family –Who?_____ ☐Int. Search/Keyword _____ ☐Other_____

Responsible Party Information

Name: Last _____ First _____ MI _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

Social Security Number: _____ Date of Birth: _____ Relation to Patient: _____

Employer: _____ Occupation: _____

Responsible Party's Spouse

Name: Last _____ First _____ MI _____

Social Security Number: _____ Date of Birth: _____ Phone: _____

Employer: _____ Occupation: _____

Dental Insurance Information (Primary Carrier)

Insured's Name: _____ **Date of Birth:** _____ **Social Security Number:** _____

Insurance Company: _____ **Phone Number:** _____

Insurance Company Address: _____

Insured's Employer: _____

CONSENT: I consent to the diagnostic procedures, treatment, and photos by the dentist necessary for proper dental care.

Parent/Guardian Signature: _____ **Date:** _____

Financial Policy

Dr. Wehking believes in providing the finest possible dental care for you and your family. We want you to feel welcome and as comfortable as possible throughout your treatment. This includes understanding your treatment options as well as our financial policy.

Financial Policy: Payment is expected and due at the time of service. This includes any deductible or patient portion, or payment in full. We accept cash, check and all credit cards. Outside financing is available through Care Credit.

Insurance: Your dental insurance is a contract between you and your dental insurance company. As a courtesy to you we will file your insurance claim, but the responsibility for payment will remain with you regardless of insurance coverage. Please understand that we can provide an insurance **estimate** to you, however we can make no guarantee that insurance will pay exactly as estimated. Insurance coverage is subject to contract restrictions, limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility to understand. We will do our best to help you understand your dental benefits, but ultimately all charges for services in our office are your responsibility. We do not file medical claims or Workmen's Compensation Plans. By signing this, you authorize our office to release any medical or dental information required to process your claims and you authorize that your insurance benefits will be paid directly to our office.

Missed Appointments and Cancellations: Your appointment is reserved exclusively for you. We ask that if you must reschedule your appointment that you provide us with at least **24 hours notice in order to avoid a charge of** $75 for each hour that was reserved for your appointment. This fee is not covered by your dental insurance and is due prior to your next appointment

Divorced Parents: The parent who brings the child in for treatment is the responsible party and the person who is responsible for paying the account in full.

Federal Truth in Lending Disclosure: All amounts reflected are due and payable upon receipt. All amounts not received after 60 days of treatment may accrue a 1.5% finance charge, simple interest 18% APR pursuant to ORS 82.0.10. If your account is past due after 60 days and is billed to you through an outside agent a $25 billing fee will apply. All accounts are due in full within 90 days.

Returned Checks: There will be a $50 service charge for any returned checks.

Attorney and Collections: If your account is turned over to a collections agency or the hands of an attorney for collections, you will pay the doctor's attorney fees and collections costs. By signing this you give permission to give any information deemed necessary to the collection agency or attorney so that they may collect your overdue account on our behalf.

Our goal is to make your visits as pleasant as possible. If you have any questions regarding your treatment plan or financial policies, please do not hesitate to ask us.

I certify that I have read and understand the policies of Complete Family & Aesthetic Dentistry.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

It is important that we know about you Medical and Dental history. These facts have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Dental History

Last Dental Exam date: _____

Last Xrays date: _____

Is your child having any problems now? ☐Yes ☐No

_____

Specific dental concerns: _____

_____

Please check all that apply:
Sensitivity to: ☐Hot ☐Cold ☐Sweets ☐Pressure
Problems with: ☐Headaches ☐Earaches ☐Neck Pains
☐Clenching ☐Grinding ☐Snoring

Has your child worn braces or other orthodontic appliances? ☐Yes ☐No
Name of orthodontist _____

Name of previous dentist:
_____

Medical History

Is your child under a physician's care? ☐Yes ☐No

For what? _____

Family physician _____

Phone #_____

Current medications:
_____

Allergies: ☐Aspirin ☐Local Anesthetic ☐Erythromycin ☐Pennicillin ☐Latex ☐Codeine ☐Other_____

Please check all that apply:

☐Heart disease ☐Heart murmur ☐Rheumatic Fever ☐Mitral valve prolapse ☐Artificial heart valve ☐Heart surgery ☐Anemia ☐Kidney Trouble ☐Ulcers ☐AIDS/HIV ☐Hepatitis A ☐Hepatitis B ☐Hepatitis C ☐Blood Transfusion ☐Allergies or Hives ☐Cold Sores ☐Epilepsy or Seizures ☐Nervousness ☐Psychiatric treatment ☐Anxiety ☐Autism ☐Tuberculosis ☐Asthma ☐Sinus trouble ☐Bleeding problems ☐ Diabetes ☐Thyroid Disease ☐Radiation treatment ☐Arthritis ☐Chemotherapy

Parent/Guardian Signature: _____ Date: _____

HIPAA

Patient Acknowledgement of Receipt of Notice of Privacy Practices and Consent/Limited Authorization & Release Form

You may refuse to sign this acknowledgement and authorization. In refusing we may not be allowed to process your insurance claims.

Section A: Patient Giving Consent:

Name _____

Address _____

Phone Number _____ Email _____

Please list any other parties who can have access to your health information (this includes step parents, grandparents, and any care takers who can have access to the patient's records:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Section B, to the patient-- Please read the following statements:

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 health care 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 health care operations of the uses and disclosures we may make of your protected health information; Including other important matters about your protected health information.

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 containing the changes. Those changes may apply to any of your protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practice, including any revisions of our Notice, at the time by contacting:

Dawn Wehking DDS
303-665-4000
204 E. Baseline Rd. Lafayette, CO 80026

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

Signature _____ Date _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal representative's name: _____ Relationship: _____