AUDUBON DENTAL PC

Welcome to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

NAME OF PATIENT:		DATE OF BIRTH:
PATIENT ADDRESS:		
CITY:	STATE:	ZIP
HOME PHONE:	WORK PHONE:	MOBILE PHONE:
SEX:	MARITAL STATUS:	SSN:
DRIVER'S LICENSE #:	E-MAIL ADDRESS:	
PATIENT'S EMPLOYER:	EMPLOYER ADDRESS:	OCCUPATION:
WHO MAY WE THANK FOR REFERRING YOU?		

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT:		
RELATIONSHIP TO PATIENT:	DATE OF BIRTH:	SSN OR IDN:
ADDRESS (IF DIFFERENT FROM PATIENT):		
RESPONSIBLE PARTY'S EMPLOYER:		
INSURANCE COMPANY:		
INSURANCE PHONE NUMBER:	GROUP NUMBER:	SUBSCRIBER NUMBER:
IS PATIENT COVERED BY ADDITIONAL INSURANCE? (IF NO, PLEASE SKIP TO NEXT SECTION)		
SUBCRIBER'S NAME:	DATE OF BIRTH:	SSN OR IDN:
ADDRESS (IF DIFFERENT FROM PATIENT):		
SUBSCRIBER'S EMPLOYER:		OCCUPATION:
INSURANCE COMPANY:		
INSURANCE PHONE NUMBER:	GROUP NUMBER:	SUBSCRIBER NUMBER:

EMERGENCY CONTACT INFORMATION

NAME OF EMERGENCY CONTACT/RELATIVE NOT LIVING WITH YOU:		
ADDRESS OF EMERGENCY CONTACT:		
HOME TELEPHONE:	WORK TELEPHONE:	OTHER:

AUDUBON DENTAL PC

PATIENT NAME:	DATE:

GENERAL PATIENT CONSENT

- I VERIFY THAT I HAVE REVIEWED THE INFORMATION IN THE HANDOUT, AND THAT IT IS CORRECT. -AVAILABLE UPON REQUEST.-
- I HEREBY AUTHORIZE **DR. MYLENE GLUECKERT REINICKE AND PERSONNEL TO DELIVER DENTAL TREATMENT AND CARE** TO MYSELF AND MY DEPENDENTS LISTED. I UNDERSTAND THAT TREATMENT MAY INCLUDE THE ADMINISTRATION OF LOCAL ANESTHETICS, SURGICAL PROCEDURES AND THE USE OF VARIOUS DENTAL MATERIALS.
- I UNDERSTAND AS A COURTESY, THAT AUDUBON DENTAL, PC WILL FILE A CLAIM WITH MY PRIMARY INSURANCE, BUT IT IS MY RESPONSIBILITY TO ENSURE PAYMENT. IF I HAVE INSURANCE THAT AUDUBON DENTAL, PC IS CONTRACTED WITH, I AUTHORIZE ASSIGNMENT OF PAYMENTS DIRECTLY TO MY PROVIDER FOR SERVICES PROVIDED TO ME.
- I UNDERSTAND THAT, UNDER THE TERMS OF THE CONTRACT THAT I HAVE WITH MY INSURANCE COMPANY, I MUST PAY ANY PREDETERMINED OR ESTIMATED CO-PAYMENTS AT THE TIME OF SERVICE.
- I UNDERSTAND THAT AUDUBON DENTAL, PC WILL FILE A CLAIM WITH MY INSURANCE COMPANY AND THAT I AM RESPONSIBLE FOR FOLLOWING UP WITH MY INSURANCE COMPANY TO INSURE MY CLAIM IS PAID WITHIN 60 DAYS OF MY VISIT DATE. I UNDERSTAND THAT AUDUBON DENTAL, PC CANNOT ACT AS AN INTERMEDIARY BETWEEN MYSELF AND MY INSURANCE CARRIER TO EFFECT PAYMENT.
- I UNDERSTAND THAT IF MY INSURANCE CLAIM IS DENIED, I WILL BE BILLED AND PAYMENT IN FULL WILL BE DUE IMMEDIATELY.
- BECAUSE I HAVE RESERVED TIME FOR TREATMENT, I UNDERSTAND THAT A **$55.00 FEE WILL BE CHARGED PER HOUR FOR APPOINTMENTS MISSED OR CANCELLED** WITHOUT AT LEAST **24 HOURS ADVANCE** NOTICE.
- I UNDERSTAND THAT FOR DEPENDENT CHILDREN, THE RESPONSIBILITY OF PAYMENT WHOSE PARENTS ARE DIVORCED RESTS WITH THE PARENT WHO SEEKS TREATMENT FOR THE CHILD. ANY COURT ORDERED RESPONSIBILITY JUDGEMENT MUST BE DETERMINED BETWEEN THE INDIVIDUALS INVOLVED.
- ALL UNPAID BALANCES ARE SUBJECT TO INTEREST OF 1.5%/MONTH, COLLECTION FEES, COURT COSTS AND ATTORNEY FEES.

PATIENT SIGNATURE:	DATE:

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- WITH MY CONSENT, AUDUBON DENTAL, PC MAY USE AND DISCLOSE INFORMATION (PHI) ABOUT ME TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (TPO). PLEASE REFER TO AUDUBON DENTAL, PC'S NOTICE OF PRIVACY PRACTICES FOR A MORE COMPLETE DESCRIPTION OF SUCH USES AND DISCLOSURES.
- I HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT. AUDUBON DENTAL, PC RESERVES THE RIGHT TO REVISE ITS NOTICE OF PRIVACY PRACTICES AT ANYTIME. A REVISED NOTICE OF PRIVACY PRACTICES MAY BE OBTAINED BY FORWARDING A WRITTEN REQUEST TO THE PRIVACY OFFICER AT AUDUBON DENTAL, PC, 2969 NORTH CIRCLE DRIVE, COLORADO SPRINGS, CO 80909.
- **WITH MY CONSENT, AUDUBON DENTAL, PC MAY CALL MY HOME OR OTHER DESIGNATED LOCATION AND LEAVE A MESSAGE ON VOICEMAIL OR IN PERSON IN REFERENCE TO ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TPO, SUCH AS APPOINTMENT REMINDERS, INSURANCE ITEMS, AND ANY CALL PERTAINING TO MY CLINICAL CARE, INCLUDING LABORATORY RESULTS AMONG OTHERS.**
- **WITH MY CONSENT, AUDUBON DENTAL, PC MAY SEND MAIL TO MY HOME OR OTHER DESIGNATED LOCATION ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TPO, SUCH AS APPOINTMENT REMINDER CARDS AND PATIENT STATEMENTS.** I HAVE THE RIGHT TO REQUEST THE PRACTICE TO RESTRICT HOW IT USES OR DISCLOSES MY PHI TO CARRY OUT TPO. HOWEVER, THE PRACTICE IS NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF DOES IT IS BOUND BY THIS AGREEMENT.
- BY SIGNING THIS FORM, I AM CONSENTING TO AUDUBON DENTAL, PC'S USE AND DISCLOSE OF MY PHI TO CARRY OUT TPO.
- I MAY REVOKE MY CONSENT IN WRITING EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ALREADY MADE DISCLOSURES IN RELIANCE UPON MY PRIOR CONSENT. IF I DO NOT SIGN THIS CONSENT, AUDUBON DENTAL, PC MAY DECLINE TO PROVIDE TREATMENT TO ME.

PATIENT SIGNATURE:	DATE:

LIST OF DEPENDENTS:

AUDUBON DENTAL PC

NAME	DATE

HEALTH HISTORY

HOW WOULD YOU DESCRIBE YOUR GENERAL HEALTH?	
ARE YOU UNDER A PHYSICANS CARE RIGHT NOW?	
PHYSICIANS NAME	TELEPHONE:

HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY? Y N			
HAVE YOU EVER BEEN HOSPITALIZED OR HAD MAJOR SURGERY? Y N			
DO YOU TAKE OR HAVE YOU EVER TAKEN PHEN -FEN OR REDUX? Y N			
DO YOU USE TOBACCO? Y N		IN WHAT FORM AND HOW MUCH?	
CIGARETTES	CIGAR	SNUFF	
DO YOU USE MARIJUANA? Y N			
DO YOU USE CONTROLLED SUBSTANCES? Y N			

PLEASE CHECK IF YOU HAVE OR HAD ANY OF THE FF CONDITIONS:

AIDS/HIV POSITIVE		CORTISONE MEDICINE		HEMOPHILIA		RENAL DIALYSIS	
ALZHEIMERS DISEASE		DIABETES		HEPATITIS A		RHEUMATIC FEVER	
ANAPHYLAXIS		DRUG ADDICTION		HEPATITIS B		RHEUMATISM	
ANEMIA		EASILY WINDED		HEPATITIS C		SCARLET FEVER	
ANGINA		EMPHYSEMA		HERPES		HIVES OR RASH	
ARTHRITIS		EPILEPSY OR SEIZURES		HIGH BLOOD PRESSURE		SICKLE CELL DISEASE	
ARTIFICIAL HEART VALVE		EXCESSIVE THIRST		HYPOGLYCEMIA		SINUS TROUBLE	
ARTIFICIAL JOINT		FAINTING SPELLS / DIZZINESS		IRREGULAR HEARTBEAT		SPINA BIFIDA	
ASTHMA		FREQUENT COUGH		KIDNEY PROBLEMS		INTESTINAL DISEASE	
BLOOD TRANSFUSION		FREQUENT DIARRHEA		LEUKEMIA		STROKE	
BREATHING PROBLEM		FREQUENT HEADACHES		LIVER DISEASE		SWELLING OF LIMBS	
BRUISE EASILY		GENITAL HERPES		MITRAL VALVE PROLAPSE		THYROID DISEASE	
CANCER		GLAUCOMA		PAIN IN JAW JOINTS		TONSILITIS	
CHEMOTHERAPY		HAY FEVER		PARATHYROID DISEASE		TUBERCULOSIS	
CHEST PAINS		HEART ATTACK/FAILURE		PSYCHIATRIC CARE		TUMORS OR GROWTHS	
COLD SORES		HEART MURMUR		RADIATION TREATMENTS		ULCERS	
CONGENITAL HEART DISORDER		HEART PACE MAKER		RECENT WEIGHT LOSS		VENEREAL DISEASE	
CONVULSIONS		HEART TROUBLE DISEASE				YELLOW JAUNDICE	

DO YOU HAVE ANY CONDITION, DISEASE, OR PROBLEM NOT PREVIOUSLY LISTED?

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NAME								DATE	
PLEASE CHECK IF YOU ARE ALLERGIC OR HAD ADVERSE REACTIONS TO ANY OF THE FF:									
LOCAL ANESTHETICS		PENICILLIN		SULFA DRUGS		BARBITUATES		OTHER ANTIBIOTICS	
ASPIRIN		ACETAMINOPHEN		IBUPROFEN		CODIENE		NARCOTICS	
METALS		LATEX OR RUBBER DAM		FOOD		ACRYLIC		OTHER	

DO YOU TAKE ASPIRIN, COUMADIN, XARELTO OR IBUPROFEN ON A REGULAR BASIS? Y N

DO YOU TAKE A BISPHOSHONATE MEDICATION SUCH AS FOSOMAX, ACTONEL?

ANY PREMEDICATION REQUIRED BY PHYSICIAN? Y N

DO YOU SNORE? Y N

ARE YOU BEING TREATED FOR SLEEP APNEA? Y N

IF YES, PLEASE CHECK WHAT TREATMENT MODALITY YOU ARE USING: CPAP BI-PAP AUTO-PAP ORAL APPLIANCE THERAPY

FOR WOMEN ONLY:

ARE YOU PREGNANT OR TRYING TO GET PREGNANT: Y N

ARE YOU NURSING? Y N

ARE YOU TAKING BIRTH CONTROL PILLS? Y N

ARE YOU DOING HORMONE REPLACEMENT THERAPY? Y N

ARE YOU AWARE THAT SOME ANTIBIOTICS CAN REDUCE THE EFFECTIVENESS OF BIRTH CONTROL? Y N

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

MEDICATION	REASON	DOSAGE

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

PATIENT SIGNATURE:

REVIEWED BY:

NOTES: