Foxfield Dental
16350 E. Arapahoe Road
Foxfield, CO 80016

(720) 870-0401

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex ☐M ☐F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Home Phone # ( ) _____ Cell Phone #1 ( ) _____ Email _____

Employer _____ Employer Phone ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone ( ) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone ( ) _____

RESPONSIBLE PARTY

Name of Person
Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone ( ) _____

Birthdate _____ Currently a patient in our office? ☐Yes ☐No

Employer _____ Work Phone ( ) _____

E-Mail _____ Cell Phone ( ) _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL DENTAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have or have had problems with any of the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to hot
☐ Bleeding Gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collecting between the teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pndimin (fenfluramine) and Redux (dexfenfluramine). ☐Yes ☐No

Have you ever had any serious illnesses or operations?? ☐Yes ☐No If yes, describe _____

Have you ever had a blood transfusion? ☐Yes ☐No If yes, give approximate dates _____

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Check (✓) if you have or have had problems with any of the following:

☐ Anemia	☐ Congenital Heart lesions	☐ Hepititis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cortisone Treatments	☐ Hernia Repair	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough, Persistent	☐ High Blood Pressure	☐ Skin Rash
☐ Artificial Joints, Pins, etc.	☐ Cough up Blood	☐ HIV/AIDS	☐ Stroke
☐ Asthma	☐ Diabetes	☐ Jaw Pain	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Epilepsy	☐ Kidney Disease	☐ Thyroid Problems
☐ Bleeding Abnormally	☐ Fainting	☐ Liver Disease	☐ Tobacco Habit
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tuberculosis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Ulcer
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Venereal Disease
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic fever	

List medications you are currently taking:

_____ _____

_____ _____

_____ _____

Allergies:

☐ Aspirin	☐ Local Anesthetic	☐ Iodine	☐ Other _____
☐ Barbiturates (Sleeping Pills)	☐ Penicillin	☐ Latex	_____
☐ Codeine	☐ Sulfa	☐ None	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my mindor child, ever have a change in health.

_____ _____

Signature of of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

FOXFIELD DENTAL
OFFICE POLICY

We would like to make your visits as pleasant, comfortable and convenient as possible. The following will explain to you our procedures and policies, which have been established so that we may serve you as promptly and efficiently as possible.

APPOINTMENTS

The doctors and staff at Foxfield Dental will make every effort to begin treatment at your appointed time; however, dental emergencies do occur frequently. When this happens, we ask for your understanding. If this causes problems with your schedule, please feel free to reschedule your appointment. If you find that you cannot keep your appointment, kindly give us at least 24 hours notice. (1 full business day) **A fee will be charged to any patient who fails to give 24 hours notice or fails to show for an appointment.** For safety reasons, we ask that only the patient be allowed in the operatory while work is being completed. Parents will be asked to come back for exams on children.

INITIAL VISIT

Unless you have an emergency, your first appointment will be a thorough examination, including appropriate x-rays. A summary (**estimate**) of services to be rendered and the cost of the completed treatment will be given to you prior to the start of any further dental treatment.

CHILDREN

We are happy to treat children of any age. We recommend that a child have his/her first dental examination between his/her third and fourth birthdays. We do not initiate dental treatment on your child's first visit unless he/she is experiencing discomfort. We may also need to refer your child to a pediatric dentist. Children must be accompanied by an adult at all times while in the reception area. **Please accompany all children (up to age 18) for their initial dental visit, as your consent is needed before any treatment can begin.** The parent or guardian who brings the child for the visit is responsible for payment independent of what a divorce decree may state. Reimbursement must be made between the divorced parties. **We CANNOT intervene.**

FINANCIAL POLICY:

ALL EMERGENCIES ARE TO BE PAID FOR IN CASH AT THE TIME OF SERVICE IF NO INSURANCE COVERAGE. We will do our best to verify your insurance eligibility and give you an estimate of benefits at the time of service. However, a quotation of eligibility and benefits from your insurance company does not guarantee payment. Please provide us with any Insurance information or Insurance changes prior to any scheduled appointments. All co-pays and other balances are due at the time of service. You are responsible for paying all charges not covered by your insurance company including all fees considered above your insurance company's "usual and customary" fee schedule. **Please remember**-your insurance benefits are contracted between you and your employer. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the dentist. After your insurance company has processed our claim, if there is any balance due from you, such as deductible or coinsurance, we will send you a statement. Balance is due upon receipt of the statement. Any account that is past due 60 days is charged a minimum $5.00 or 1.5% service charge. We are unable to carry **ANY** account balance past 90 days.

Should this office be required to employ a collection service to collect delinquent accounts; you agree to pay all finance charges, collection cost, attorney fees, and any other cost that may be incurred to enforce collection of any amount outstanding. Once the account has been sent to collections, we no longer have control of the account and can no longer discuss details of your account with you. **A $50 fee will be charged for returned checks.**

I have read and understand these policies:

Signature of Patient/Guardian _____ Print Name _____ Date: _____

Foxfield Dental

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of progress to your insurance company.

We may share your medical information with our business associates, such as a billing service. We may have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example we may send postcards or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You must sign a release form for the information.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us your written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for copies.

You have the right to request amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file.If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice. If you would like a copy, please ask the receptionist. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue S. W., Room 509f, Washington DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our privacy officer (see list on back for contact information.)

This notice goes into effect as of April 14, 2003.

Acknowledgement: I have received a copy of this office's Notice of Privacy Practices.

In order to prevent unauthorized access to our patient's vital information, we have established an identity theft program. All vital documents, both paper and electronic will be shredded prior to disposal. No credit card numbers will be kept on file. Checks will be kept in a safe place and any copies will be destroyed properly. Charts will be kept in a secure area with an alarm system to prevent theft. Patients will be notified if there is a breech in out identify theft program.

Date: _____

Signed: _____ Print Name: _____

If signing as a parent of guardian, please note the name of the patient:(s)

Office Contact Information
Foxfield Dental
16350 E. Arapahoe Road, Suite 114
Foxfield, CO 80016
Privacy Officer: Renee M.