Welcome!

PERFECT TEETH™

Today's Date _____

Please give us some information....

The Account Holder/Head of Household

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss _____
Last Name First Name M.I.

Address _____
Street City State Zip Code

Home Phone _____ Cell _____ Work _____ E-mail _____

Birth Date _____ Employer _____

Employer's Address _____
Street City State Zip Code

Driver's Lic. #_____ OR Social Security # _____ - _____ -_____

The Patient Information

Medicaid ID # _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss _____
Last Name First Name M.I.

Birth Date _____ Relationship to Account Holder _____

Would you like to learn more about options to pay for your dental treatment? ❑ Yes ❑ No

Dental Insurance

Insurance Co. _____
Name Address City State Zip Code

Phone# _____ Plan# _____ Group/Policy# _____ ID# _____ Effec. Date _____

Name of Insured _____ Birth Date _____ Sex_____

Relationship to Patient_____ Social Security # _____– _____– _____

Insured's Address _____
Street City State Zip Code

Insured's Employer _____
Name Address City State Zip Code

Does this Policy Cover ❑ Spouse ❑ Children

About Your Family

Name	Birth Date	Name	Birth Date

Other Dental Insurance

Insurance Co. _____
Name Address City State Zip Code

Phone # _____ Plan #_____ Group/Policy # _____ Effec. Date _____

Name of Insured _____ Birth Date _____ Sex_____

Relationship to Patient_____ Social Security # _____– _____– _____

Insured's Address _____
Street City State Zip Code

Insured's Employer _____
Name Address City State Zip Code

Does this Policy Cover ❑ Spouse ❑ Children

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PERFECT TEETH™

HEALTH HISTORY

Patient Name _____ **Medicaid ID #**_____

It is important that we know about your medical history. Many things have a direct bearing on our health. We will review the questionnaire and discuss it with you in detail. Information you give us is strictly confidential and will not be released to anyone without your written permission.

Physician's name_____**Date of last physical examination**_____

In case of emergency, notify _____ **Phone #**_____

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

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Heart Problems	❑	❑	Stroke/TIA	❑	❑	Tuberculosis	❑	❑	Are You Pregnant or Could You Be
❑	❑	Heart Murmur	❑	❑	Pacemaker/Defibrillator	❑	❑	Emphysema/Chronic Bronchitis	❑	❑	Are You Nursing
❑	❑	High Blood Pressure	❑	❑	Nervous System Problems	❑	❑	Asthma	❑	❑	Oral Contraceptives
❑	❑	Low Blood Pressure	❑	❑	MS/MD/Cerebral Palsy	❑	❑	Lung/COPD Problems	❑	❑	Snoring and/or Sleep Apnea
❑	❑	Bleeding Problems	❑	❑	Epilepsy	❑	❑	Arthritis _____	❑	❑	CPAP/O2 at Night
❑	❑	Anemia	❑	❑	Diabetes (Circle: Type 1 Type 2)	❑	❑	Thyroid Disorder	❑	❑	Alcohol Use
❑	❑	Bleeding Disorder	❑	❑	Dementia/Alzheimer's	❑	❑	Ulcers/Other GI Disease	❑	❑	Drug Use
❑	❑	AIDS/HIV	❑	❑	Psychiatric Care	❑	❑	Liver Disease	❑	❑	Tobacco Use
❑	❑	Blood Transfusion Date _____	❑	❑	Lupus or other Connective Tissue Disease	❑	❑	Hepatitis (circle: A B C D E)	❑	❑	ADHD
❑	❑	Prosthetic Implants	❑	❑	Kidney Disease _____	❑	❑	Herpes	❑	❑	Autism
❑	❑	Musculoskeletal Issues	❑	❑	Rheumatic/Scarlet Fever	❑	❑	Cancer/Malignancies	❑	❑	Down Syndrome
❑	❑	Circulatory Problems				❑	❑	Sinus Problems			
						❑	❑	Excessive Dry Mouth			

Explanation of Above: _____

_____

Medications: List ALL medications you are taking (prescribed or over the counter): _____

_____

Do you have any allergies (latex, anesthetics, penicillin, sulfa, codeine, etc.)? ❑ Yes ❑ No Explain: _____

_____

Are you now, or have you ever taken a class of drugs called Bisphosphonates like Fosamax or Boniva for osteoporosis treatment?

❑ Yes ❑ No Explain:_____

Have you had any clicking or discomfort in your jaw joints, and/or headache, neck, or back pain? ❑ Yes ❑ No Explain: _____

_____

Have you or anyone in your family had any problems with anesthesia? ❑ Yes ❑ No Explain:_____

_____

Are you currently under the care of a physician? ❑ Yes ❑ No Explain: _____

_____

Physician's Name: _____ Phone: _____

Have you been hospitalized in the past 5 years? ❑ Yes ❑ No Explain:_____ _____

_____

Height: _____ Weight:_____

Signature _____ **Date** _____

DENTIST HEALTH HISTORY INITIAL / UPDATES

Dates	By	Notes

PERFECT TEETH™

MEDICAID

OFFICE POLICY

Payment will be expected at the time of service for all non-covered Medicaid fees unless a financial agreement is in place.

Third party financing may be available for patients requiring extensive treatment ($800 or more). This type of financing must be approved in advance. The terms of this contract consist of six equal installments, free of interest or finance charges. The total financed amount however, must be paid in full within 12 months. A finance charge of 18% APR (1.5% a month) will be added to the total balance on all accounts over 60 days past due.

If at any time you have questions regarding any treatment, fees, or services, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding, to rectify an injustice, or to preserve a friendship.

Photo Identification: Please present a valid photo ID and Medicaid ID card prior to each appointment.

Children in the office: Please make arrangements for your non-scheduled children prior to your visit. Children should not be left unattended in the reception area. All children, 17 years of age and under, scheduled for treatment must have a parent or legal guardian present in the office during their appointment.

Cellular phones/pagers: We request all cellular phones and pagers be turned off or to silent mode during your appointment.

Family/Friends: In order to comply with regulations set by Perfect Teeth, and for the safety and comfort of our patients and employees, no friends or family members will be permitted to accompany patients in the treatment area during the appointment. Any patients with special needs can make necessary arrangements with the office manager prior to their appointment.

We reserve the right to dismiss any patient from our practice for excessive missed appointments, or for inappropriate behavior in our office or on the phone.

I have read the policies and agree with the terms outlined above.

I acknowledge that I am responsible for payment of all charges for treatment administered by Perfect Teeth as outlined above.

Medicaid ID#: _____

Printed Name: _____

Responsible Party Signature: _____

Date: _____

PERFECT TEETH™

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, designated Perfect Teeth personnel may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). This may include the use of phone calls, letters, emails, facsimiles, and text messages. Please refer to Perfect Teeth's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I fully understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. Perfect Teeth reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the designated Perfect Teeth HIPAA Compliance/Security Officer at Birner Dental Management Services, Inc., 1777 S. Harrison St. Suite 1400, Denver, CO 80210.

With my consent, Perfect Teeth personnel may mail to my home or other designated location any items that will assist Perfect Teeth in carrying out Treatment, Payment and Healthcare Operations (TPO), such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

When my information is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient that is outside of Perfect Teeth's control. If I do not sign this consent, Perfect Teeth may decline to provide treatment to me, forward insurance claims on my behalf, or provide PHI to necessary sources outside of the Perfect Teeth organization.

I have the right to revoke this authorization in writing except to the extent that Perfect Teeth has already made disclosures in reliance upon my prior consent. My written revocation must be forwarded to the designated Perfect Teeth HIPAA Compliance/Security Officer at Birner Dental Management Services, Inc., 1777 S. Harrison St. Suite 1400, Denver, CO 80210 to become legally effective and/or binding.

By signing this form, I am consenting to Perfect Teeth's use and disclosure of my PHI to carry out TPO.

_____	_____
Patient's Name	Legal Guardian's Name
_____	_____
Signature of Patient or Legal Guardian	Date

MEDICAID ID # _____

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PERFECT TEETH™

Patient Authorization for Practice to Release Protected Health Information to Third Parties

By signing this authorization, I authorize Perfect Teeth personnel to use and/or disclose certain **Protected Health Information (PHI)** about me to or for the party or parties necessary to complete **Treatment, Payment and Healthcare Operations (TPO)**.

This authorization permits Perfect Teeth to use or disclose the minimum necessary **Individually Identifiable Health Information (IIHI)** to complete my TPO. This authorization includes all IIHI and PHI unless restricted as delineated below.

I authorize Perfect Teeth to share my Protected Health Information (PHI) with:

☐ Spouse/Partner: _____

☐ Parent(s): _____

☐ Sibling/Other: _____ _____
Relationship

Under no circumstances is my PHI to be shared with: _____

_____

I authorize Perfect Teeth to email my PHI to: _____

____ I understand that this message may no longer be encrypted once it leaves Perfect Teeth's secure network.

I authorize Perfect Teeth to leave me a voicemail message at: _____

☐ Detailed (treatment and follow-up information, appointment time, etc.)

☐ General (no detailed information)

When my information is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Perfect Teeth has acted in reliance upon this authorization. My written revocation must be forwarded to the designated Perfect Teeth HIPAA Compliance/Security Officer at Birner Dental Management Services, Inc., 1777 S. Harrison St. Suite 1400, Denver, CO 80210 to become legally effective and/or binding.

I understand that this consent shall remain in effect until revoked in writing.

_____ _____
Patient's Name Legal Guardian's Name

_____ _____
Signature of Patient or Legal Guardian Date

MEDICAID ID # _____

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PERFECT TEETH

HELP US GET TO KNOW YOU BETTER!

Name _____ Date _____

By answering the following questions we will be able to better take care of your needs.

When was your last dental visit? _____

Why did you leave your last dentist? _____

Have you had any problems with previous dental treatment? Yes/No Explain: _____

_____

When was your last teeth cleaning? _____

How did you hear about us? _____

Rate Your Smile: 

Yes ❑ No ❑ Do you avoid brushing any part of your mouth?

Yes ❑ No ❑ Do your gums bleed when you brush?

Yes ❑ No ❑ Would you like to remove and replace any mercury/amalgam/silver fillings?

Yes ❑ No ❑ Are your teeth sensitive to sweets, hot/cold, or biting pressure?

Yes ❑ No ❑ Do you have any missing teeth?

Yes ❑ No ❑ Are you interested in replacing any of your missing teeth?*

Yes ❑ No ❑ Are you interested in solutions to improve your breath?

Yes ❑ No ❑ Does dental treatment make you nervous?

Yes ❑ No ❑ Would you like whiter teeth?

Yes ❑ No ❑ Would you like straighter teeth?*

Yes ❑ No ❑ Would you like to close spaces in your teeth?*

Yes ❑ No ❑ Would you like to repair chips in your teeth?

Yes ❑ No ❑ Have your wisdom teeth been extracted?

Yes ❑ No ❑ Do you have habits such as nail biting, pencil biting or lip biting?

Yes ❑ No ❑ Do you have habits such as thumb sucking or mouth breathing?

Yes ❑ No ❑ Do you clench or grind your teeth?

What is your biggest dental concern today? _____

_____

Lastly, if you could wave a magic wand, what would you want your teeth to look like? _____

_____

***Direct referral to specialist.**

Revised 11/13