Patient Health Information

Name:_____ Date of birth:_____

Address:_____

Phone:_____(home) _____(cell) _____(work)

Email Address:_____ Would you like to get email/text reminders? ❑Yes ❑No

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Your current physical health is: ❑ Good ❑ Fair ❑ Poor

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

Physician's Name:_____ Date Last Seen:_____

Please explain: _____

Have you ever had any surgical procedures? ❑ Yes ❑ No

Please list each one: _____

Are you taking or ever taken a Bisphosphonate medication like Fosomax, Zometa, Boniva, Aredia or Reclast? ❑ Yes ❑ No

Are you taking any medications? ❑ Yes ❑ No

Please list each one: _____

Do you use tobacco in any form?: ❑ Yes ❑No

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
❑	❑	Abnormal Bleeding	❑	❑	Heart Attack: When?____	❑	❑	Stroke
❑	❑	Alcohol/Drug Abuse	❑	❑	Heart Disease	❑	❑	Thyroid Problems
❑	❑	Allergies	❑	❑	Heart Murmur	❑	❑	Tuberculosis
❑	❑	Arthritis	❑	❑	Heart Valve Surgery			
❑	❑	Artificial Heart Valve	❑	❑	Hepatitis			
❑	❑	Asthma	❑	❑	High Blood Pressure			
❑	❑	Cancer	❑	❑	History of Eating Disorder			
❑	❑	Chemotherapy/Radiation	❑	❑	Joint Replacement/Artificial			
❑	❑	Chest Pain	❑	❑	Kidney Problems			
❑	❑	Congenital Heart Defect	❑	❑	Liver Disease			
❑	❑	Diabetes	❑	❑	Low Blood Pressure			
❑	❑	Emphysema	❑	❑	Pacemaker			
❑	❑	Epilespy	❑	❑	Psychiatric Care			
❑	❑	Fainting Spells	❑	❑	Radiation			
❑	❑	Frequent Headaches	❑	❑	Seizures			
❑	❑	Glaucoma	❑	❑	Sexually Transmitted Disease			
❑	❑	HIV+ Aids	❑	❑	Sinus Problems			

Yes	No	Allergies
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Latex
❑	❑	Penicillin
❑	❑	Tetracyline

Yes	No	If Female,
❑	❑	Are you taking birth control pills?
❑	❑	Are you pregnant? If so, # of weeks__
❑	❑	Are you nursing?

Is there any other disease/condition not listed above?_____

Please check if you have had or have any of the following:

❑ Bad breath
❑ Bad tastes
❑ Bite nails/objects
❑ Bleeding gums
❑ Chew on one side
❑ Clenching/grinding teeth
❑ Clicking/popping of jaw
❑ Difficulty chewing
❑ Dry mouth
❑ Gag easily
❑ Infection in gums
❑ Jaw pain/soreness
❑ Loose teeth
❑ Mouth sores
❑ Missing teeth
❑ Sensitive gums
❑ Sensitive to: ❑Hot ❑Cold ❑Sweets
❑ Stained teeth

I understand that the information that I have given today is the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ **Date:**_____

Trusted.Preferred.Genuine

Ian W. Morse, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

I, _____ have received a copy of this office Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

_____

_____

OFFICE POLICY

Appointment Cancellation Policy

Your appointment time is reserved specifically for you. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. As a courtesy if you are unable to keep your appointment, please give at least one business days' notice. Otherwise, after two missed or less than one business day cancelled appointments, a deposit will be required to reschedule.

Authorization and Release

I authorize Dr. Morse to release any information including the diagnosis and the records of any treatment or examination rendered during the period of such dental care to the third party payers (insurance providers) and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Morse/South Metro Family Dentistry.

Insurance and Financial Arrangements

As a courtesy we offer you an estimate for recommended treatment. All estimated portions are due at the time of service, unless other arrangements are made. Cash, check and credit cards are accepted. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Our team of treatment coordinators are very effective at maximizing your insurance benefits. We will do everything in our power to get full payment from you insurance provider. We are happy to help answer any insurance plan questions that you have and we encourage you to refer to your benefits or call your insurance customer service.

Late Charges

If I do not pay the entire balance within 25 days of the monthly billing date, a late charge of 1.5% on the unpaid balance will be assessed each month. In the case of default on payment on this account, I agree to pay collection costs and reasonable fees incurred in attempting to collect on this amount or any future outstanding account balances.

Sign below in acceptance of this policy.

Name: _____ Date: _____

Emergency Contact Information

In the event of an emergency, who should we contact?

Name: _____ Relationship: _____ Phone #: _____

Dental Insurance Information

Primary Insurance:

Insurance Co: _____ Phone #: _____

Name of Insured: _____ Relation to insured: _____

Insured DOB: _____ Insured SSN/ID#: _____

Employer: _____

Secondary Insurance:

Insurance Co: _____ Phone #: _____

Name of Insured: _____ Relation to insured: _____

Insured DOB: _____ Insured SSN/ID#: _____

Employer: _____

AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than the terms specifically described below.)

To: _____ **Fax:** _____

Patient Name: _____

Release to: South Metro Family Dentistry

6950 S. Holly Circle Suite #202, Centennial Colorado 80112

Phone: 303-770-2252 / **Fax:** 303-773-2151

E-Mail: office@southmetrodentistry.com

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

Information Requested:

__**X**___Copy of complete dental chart

__**X**___Copy of dental x-rays

Purpose or need for which in for is to be used:

_____Transfer of Records _____Second Opinion

AUTHORIZATION: *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it.*

_____ _____

Patient Name (print) Person Authorized to Sign for Patient

_____ _____

Signature Date

SOUTH METRO™
FAMILY DENTISTRY

6950 S. Holly Circle Suite #202
Centennial, Colorado
80112