ELEVATION
FAMILY AND COSMETIC DENTISTRY

PATIENT INFORMATION

Name:_____
Last First Middle Initial Preferred Name

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex:_____

Mailing Address:_____
Street City State Zip Code

Home Phone:_____

Cell Phone:_____ Okay to receive text messages?: Y or N

Work Phone:_____ If new, how did you hear about us? _____

E-mail Address:_____ Okay to receive Emails?: Y or N

PRIMARY Insurance Information:

Subscriber's Name: _____ Relationship to Patient_____
Subscriber's SSN: _____-_____-_____ Date of Birth of Subscriber: _____/_____/_____
Employer:_____
Insurance Company: _____ Plan/Group #: _____
Patient ID # (If Applicable): _____ Insurance Phone #: _____

Secondary Insurance Information (if applicable):

Subscriber's Name: _____ Relationship to Patient_____
Subscriber's SSN: _____-_____-_____ Date of Birth of Subscriber: _____/_____/_____
Employer:_____
Insurance Company: _____ Plan/Group #: _____
Patient ID # (If Applicable): _____ Insurance Phone #: _____

Appointments and Cancellations

We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who needs to be seen. We feel our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared and reviewed, and special instruments are readied for your visit. We strive to be prompt and respectful of your time. **There is a charge for not showing up for scheduled appointments.**

Signature: _____ ***Date:*** _____

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Health History Information

Patient Name: _____ DOB: _____

1. Do you or have you ever been treated for: (**Please Circle Either "Y" (YES) or "N" NO for all)**

Y / N	Asthma	Y / N	Radiation Therapy	Y / N	Thyroid Problems
Y / N	High Blood Pressure	Y / N	Emphysema/COPD	Y / N	Osteoporosis
Y / N	Heart Attack- YEAR _____	Y / N	Tuberculosis	Y / N	Are you pregnant?
Y / N	Heart Murmur/MVP	Y / N	Diabetes: Last HA1C: _____		Trimester: _____
Y / N	Cardiac Stent/Pacemaker		Last Blood Sugar: _____	Y / N	Are you nursing?
Y / N	Stroke/TIA-Year:_____	Y / N	Stomach Ulcers/GERD	Y / N	Do you take Birth
Y / N	Artificial Joints- YEAR_____	Y / N	Kidney Problems		Control?
Y / N	Cancer: YEAR: _____	Y / N	Liver Disease/Hepatitis		
Y / N	Chemotherapy	Y / N	Epilepsy/Seizures		

2. **Primary Care Physician**: _____ Phone #: _____
3. What medications are you currently taking (Prescribed or OTC): _____
_____
4. Y / N Allergies: _____
5. Y / N Joint Replacements or Back Surgery? _____ **YEAR** _____
Surgeon's Name: _____Phone #: _____
6. Y / N Any Surgeries in the last Five years? Explain: _____
7. Y / N Have you ever been told to premedicate before dental treatment?
8. Y / N Do you drink? Drinks Per Week? _____
9. Y / N Do you smoke? Packs Per Day? _____ Y / N Smokeless Tobacco?
10. Y / N Have you ever been told that you grind your teeth?
11. Y / N Does your jaw click or pop?
12. Y / N Have you ever been told you have gum problems?
13. Y / N Are you currently taking Plavix or any blood thinning medications?
14. Y / N Do you have any other Health information you would like to share that is not listed? Explain:
_____

To the best of my knowledge the foregoing questions have been answered accurately. I grant the right of the dentist to release health information obtained from me to third party payors (insurance) or other health practitioners.

Patient or Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

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Privacy Notice

Elevation Family and Cosmetic Dentistry is required by law to maintain the privacy of your health information and to provide you the notice of its legal duties as well as the privacy practices with respect to your health information. If you have any questions about any part of this notice, or if you want more information about your privacy rights, please contact our office at 719-481-6788. If someone is not available to answer your questions immediately, a personal conference appointment can be made in person or by telephone within two working days.

Elevation Family and Cosmetic Dentistry reserves the right to amend this Privacy Notice at any time in the future. If the Privacy Notice is amended, the new provisions will be effective for all the information that it maintains. Until such amendment is made, Elevation Family and Cosmetic Dentistry is required by law to comply with this Privacy Notice.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Elevation Family and Cosmetic Dentistry with my authorization and consent to use and disclose my protected health care information for the purposes or treatment, payment, and health care operations as described in the Privacy Notice.

_____
Print Patients Name

_____
Patient or Guardian's Signature

_____
Date

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.
By signing this form you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice (Elevation Family and Cosmetic Dentistry) reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosers will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we call, email, or send texts to confirm appointments? YES NO
May we leave a message on your answering machine at home or cell? YES NO
May we discuss your medical or dental condition with any of your family members? YES NO

- If YES please list the family members: _____

_____

This consent was signed by: _____
(PRINT NAME)
Signature: _____ Date: _____

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Financial Policy

Our goal is to provide you with the best dental treatment that will help you maintain optimal dental health. In order to help preserve this goal, we do ask that all fees not covered by insurance are paid at the time of service. We understand that this is not always possible, and we have payment plans available if needed. Our staff will do their best to estimate, based on your insurance plan benefits, the balance that remains after insurance pays. If there is a difference, you will be billed.

We offer a 5% discount for uninsured patients.

Payments accepted are Personal Check, Cash, Visa, MasterCard, or Discover. As a convenience to you, payments by credit or debit can be processed over the phone, or on our secure website. There is a $*50 charge for all returned or stopped checks.*

All patients, or their parent/guardian if under the age of 18 years of age, are personally responsible for the fees which they incur. This is regardless of any insurance coverage which may apply. In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a minor will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

If your account has not been paid in full within 90 days, or as agreed to, it will be turned over to a collection agency. *A $50 fee will be added as a collection fee*.

CareCredit is now accepted as a payment option, however payment must be received at the time services are rendered, unless prior arrangements are made with our billing department and the office supervisor. Please inquire for more information.

A $50 charge will be applied to your account if you fail to cancel your appointment within 24 hours and do not show up for an appointment.

If you are covered under a dental insurance policy, please read:
Your insurance policy is a contract between you and your insurance company. We are not party to that contract. However, it is our pleasure to assist you in the maximizing of your insurance benefits by completing and submitting claim forms to your insurance company. We do ask that you be as familiar as possible with your own dental plan and be responsible for monitoring all benefits and carrier payments pertaining to your annual maximum dental benefit. We realize that dental insurance can be quite overwhelming and confusing. We will do our best to estimate insurance benefits upon your request. Please understand

that it is only an estimate based upon the information available to us at the time. You are ultimately responsible for any and all amounts not paid by your insurance.

Our treatment plans are always based on what the doctor believes is the best way to achieve and maintain your optimal dental health. Unfortunately, insurance companies do not base benefits on this standard. Your benefits are based on the policy your employer purchases from your insurance company. When it comes to more expensive treatment plans, even if recommended treatment is a covered benefit, it is advised to submit what's called a "Pre-Treatment Estimate" or a "Preauthorization". A preauthorization is sent to your insurance company to ensure they will pay for a specific procedure. Even if the preauthorization clearly states that a procedure will be covered, the patient may learn later that the estimated benefit will not be paid at all. This is rare, but it does happen. When it does, the patient is still obligated to pay the entire bill themselves.

I have read, understand and agree to all terms listed above.

_____

Signature of Patient or Guardian

_____

Date