Patient Information

Patient Name: _____ Date: _____
Last First MI Preferred Name

Address: _____
Street Apt # City State Zip Code

Phone #s: Home _____ Work _____ Mobile _____

Gender: **M F** Marital Status: **Married Single Divorced Minor** (under 18) Birthdate:_____

SSN: _____ Email address: _____ Occupation _____

Spouse or Responsible Party Information (if not patient)

Name: _____Date: _____
Last First MI Preferred Name

Address: _____
Street Apt # City State Zip Code

Phone #s: Home _____ Work _____ Mobile _____

Gender: **M F** Marital Status: **Married Single Divorced Minor** (under 18) Birthdate:_____

SSN: _____ Email address: _____ Occupation _____

Dental Insurance

Primary

Insurance Company: _____ Ins Co Phone# _____

Policy Holder (employee) _____ SSN/ID#_____

Employer: _____ Group # _____

Patients Relationship to Policy Holder: **Self Spouse Child Other**

Secondary

Insurance Company: _____ Ins Co Phone# _____

Policy Holder (employee) _____ SSN/ID#_____

Employer: _____ Group # _____

Patients Relationship to Policy Holder: **Self Spouse Child Other**

EMERGENCY CONTACT INFORMATION

In case of emergency, please contact: _____ Ph #: _____

REFERRAL INFORMATION

Have you ever been a patient of ours: YES NO

Has any member of your family ever been a patient of ours? YES NO If yes: _____

Who may we thank for referring you to our office? _____

Talbot Dentistry 925 Main Street, Suite B, Broomfield, CO 80020(303) 466-2221

Office Financial Policy

We view our patient relationships with a deep sense of responsibility. A major part of that responsibility is to help our patients understand and plan for their oral health along with providing each patient the highest quality of dental care. We ask that you please read, agree to, and sign the agreement before any treatment is rendered

REGARDING INSURANCE

For decades dental insurance has been an integral part of oral health planning; however, in the past few years it has become more difficult for the dental practice to work with insurance companies. We are a third party to the contract and insurance companies are not obligated to share your confidential information with us or required to send payment to us. **If we know your insurance plan will not pay us directly, then you will be responsible for full payment at time of service.**

There are constant changes being made by you or employer and insurance carriers to your coverage, deductibles, and annual maximum. These changes are not always shared with us. Therefore, it is impossible for us to know EXACTLY what your policy covers. We provide the courtesy of submitting the claim on your behalf and supporting you with maximizing your benefits. However, we are unable to carry your expected insurance portion for longer than 60 days. Policy coverage, changes and follow-up on unpaid claim is your responsibility. _____ **(Initial)**

PAYMENT OPTIONS

We accept Cash, Check, Visa, American Express, Discover, and Mastercard.

A $30 fee will be assessed on all returned checks. _____ **(Initial)**

APPOINTMENT POLICY

- A 24-hour notice is required by all patients for any cancellations.
- A $50 fee will be assessed for any missed appointments without the requested 24-hour notice. Exceptions may be made for special circumstances or emergencies at the discretion of our office.
- A $100 deposit is required for appointments requiring 1 ½ hours or more. This will be applied to any fees upon completion of your treatment. Please note, should you fail to follow the cancellation policy, you will forfeit your deposit. _____**(Initial)**

OFFICE HOURS:

Monday 7:00 AM – 4:00 PM (CLOSED ALTERNATING MONDAYS)
Tuesday 7:00 AM – 4:00 PM
Wednesday 7:00 AM – 4:00 PM
Thursday 7:00 AM – 4:00 PM
Friday 7:00 AM – 1:00 PM (CLOSED ALTERNATING FRIDAYS)

I understand and agree to the policies stated above.

_____ _____

Signature **Date**

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 the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

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. 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 reserves the right to change the privacy policy as allowed by law

The practice has the right to restrict the use of 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 disclosures will then cease

The practice may condition receipt of treatment upon execution of this consent

May we phone, email or send a text to you to confirm appointments?	YES	NO
May we leave a message on your voicemail at home or on your cell phone?	YES	NO
May we discuss your dental conditions with any member of your family?	YES	NO

If YES, please name the family members allowed:

_____

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Talbot Dentistry,PC

www.talbotdentistry.com jtalbotdentistry@gmail.com
925 Main Street Suite B • Broomfield, CO 80020 (303)466-2221

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient Name and Date of Birth *

_____

_____

Are you under a physician's care? * ◯ Yes ◯ No

Have you ever been hospitalized or had a major operation? * ◯ Yes ◯ No

Have you ever had a serious head or neck injury? * ◯ Yes ◯ No

Please list any medications, vitamins, or drugs you are taking. *

_____

_____

_____

Do you take or have you ever taken Phen-Fen of Redux? * ◯ Yes ◯ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? * ◯ Yes ◯ No

Are you on a special diet? * ◯ Yes ◯ No

Do you use tobacco? * ◯ Yes ◯ No

Do you use controlled substances? * ◯ Yes ◯ No

Women:

◯ Are you pregnant or trying to get pregnant?
◯ Are you nursing?
◯ Are you taking oral contraceptives?

What are you allergic to? * _____

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

◯ Acid Reflux / GERD	◯ ADD / ADHD	◯ AIDS/HIV Positive	◯ Anaphylaxis
◯ Anemia	◯ Angina	◯ Arthritis/Gout	◯ Artificial Heart Valve
◯ Artificial Joint	◯ Asthma	◯ Blood Disease	◯ Blood Transfusion
◯ Breathing Problem	◯ Bruise Easily	◯ Cancer	◯ Chemotherapy
◯ Chest Pains	◯ Cold Sores/Fever Blisters	◯ Congenital Heart Disorder	◯ Convulsions
◯ COPD / Emphysema	◯ Cortisone Medicine	◯ Dementia	◯ Diabetes
◯ Drug Addiciton	◯ Easily Winded	◯ Eating Disorders	◯ Epilepsy or Seizures
◯ Excessive Thirst	◯ Fainting Spells / Dizziness	◯ Frequent Cough	◯ Frequent Diarrhea
◯ Frequent Headaches	◯ Glaucoma	◯ Hay Fever	◯ Heart Attack / Failure
◯ Heart Murmur	◯ Heart Pacemaker	◯ Heart Trouble / Disease	◯ Hemophilia
◯ Hepatitis A	◯ Hepatitis B or C	◯ Herpes	◯ High Blood Pressure

◯ High Cholesterol	◯ Hives or Rash	◯ Hypoglycemia	◯ Irregular Heartbeat
◯ Kidney Problems	◯ Leukemia	◯ Liver Disease	◯ Low Blood Pressure
◯ Lung Disease	◯ Mitral Valve Prolapse	◯ Multiple Sclerosis	◯ Osteoporosis
◯ Pain in Jaw Joints	◯ Parathyroid Disease	◯ Parkinson's	◯ Psychiatric Care
◯ Radiation Treatments	◯ Recent Weight Loss	◯ Rheumatic Fever	◯ Rheumatism
◯ Scarlet Fever	◯ Shingles	◯ Sickle Cell Disease	◯ Sinus Trouble
◯ Sleep Apnea	◯ Spina Bifida	◯ Stomach / Intestinal Disease	◯ Stroke
◯ Swelling of Limbs	◯ Thyroid Disease	◯ Tonsilitis	◯ Tuberculosis
◯ Tumors or Growths	◯ Ulcers	◯ Venereal Disease	◯ Yellow Jaundice

Have you ever had any serious illness not listed above? * _____

Comments: *

_____

_____

_____

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.

Signature _____ **Date** _____

Response Date: _____