CASTLE ROCK
DENTAL HEALTH
2 OAKWOOD PARK PLAZA STE 206 | CASTLE ROCK CO, 80104 | (303) 663-9600

Patient Information

In order for us to better serve you; please fill in the following information completely:

Name Mr / Mrs / Miss _____ Date of Birth _____

Home Phone _____ Cell Phone _____ Soc.Sec.No. _____

Address _____ City _____

State _____ Zip _____ Email address _____

Who may we thank for this referral? _____

Circle correct choice: Child Single Married Divorced Separated

Present Employer _____ Business Phone _____

Address _____

Spouse's Full Name _____

Spouse's Employer _____ Business Phone _____

Address _____

For Child or Teen, please list:

Father's Name _____ Business Phone _____

Mother's Name _____ Business Phone _____

Who may we contact in case of an emergency? _____ Phone _____

Who will be responsible for this account? _____

If insured, name of dental insurance company _____ Group # _____

MEDICAL HISTORY

Name, Address and Phone Number of Physician _____

_____

Health Insurance Company Name _____

When was your last physical examination? _____

Are you now under the care of a physician? Yes No

If yes, for what reason? _____

_____

(Women) Are you pregnant? Yes No If yes, how long? _____

Are you allergic to: Penicillin Codeine Local Anesthetics Latex Other: _____

Are you currently taking any medications? _____

_____

Do you smoke tobacco? _____ If yes, type _____ Frequency _____

Have you ever taken Phen-fen or Redux? Yes No

Do you want to be informed by the doctor on every step/procedure that is done? Yes No

Do you like music being played during your visit? Yes No

CASTLE ROCK
DENTAL HEALTH
2 OAKWOOD PARK PLAZA STE 206 | CASTLE ROCK CO, 80104 | (303) 663-9600

Please present a valid driver's license

Do you have or have you ever had:

Heart disease / Heart Attack / Stroke ..... Yes No
Heart murmur ..... Yes No
Rheumatic fever ..... Yes No
Congenital heart defects / Mitral Valve Prolapse ..... Yes No
Prosthetic Implant ..... Yes No
Abnormal blood pressure High/ Low ..... Yes No
Ulcers / Stomach Problems ..... Yes No
Tuberculosis or lung disease ..... Yes No
Diabetes / Hypoglycemia ..... Yes No
Epilepsy..... Yes No
Anemia ..... Yes No
Thyroid problem ..... Yes No
Chemical dependency ..... Yes No
Excessive or prolonged bleeding ..... Yes No
HIV / AIDS / ARC ..... Yes No

Arthritis / Rheumatism ..... Yes No
Kidney problems ..... Yes No
Fainting spells / Seizures / Epilepsy ..... Yes No
Jaundice / Liver problems ..... Yes No
Hepatitis ..... Yes No
Asthma or hay fever ..... Yes No
Sinus problems ..... Yes No
Tumors / Cancer ..... Yes No
Stroke ..... Yes No
Glaucoma ..... Yes No
Radiation therapy / chemotherapy ..... Yes No
Psychiatric care ..... Yes No
Tonsillitis ..... Yes No
Neurologic problems ..... Yes No

DENTAL HISTORY

Former Dentist _____

When did you last visit a Dentist? _____ X-rays taken? Yes No

Are you happy with the appearance of your teeth? Yes No

Are you aware of a dental problem? Yes No Explain: _____

_____

_____

Do your gums bleed? Yes No
Have you ever been told you have gum disease? Yes No
Does food collect between your teeth? Yes No
Do you clench or grind your teeth? Yes No
Do you have pain around your ears? Yes No
Unusual sounds in the ear? Yes No
Frequent blisters on lips or mouth? Yes No
Swelling or lumps in your mouth? Yes No
Are your teeth sensitive to: Sweet Cold Heat Pressure
How often do you brush? _____ Use dental floss? _____
Anything else that would be valuable for me to know? : _____

CONSENT FOR DENTAL TREATMENT

To the best of my knowledge the above statements are true and factual. Any misrepresentation releases liability of LCL,DDS PC and its employees. While recognizing the benefits of a pleasing and healthy smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment but should be considered when making treatment decisions. Benefits of dental treatment can include, relief of pain, the ability to chew properly, and the confidence of social interaction that a pleasing smile can offer. Nonetheless, there are some common risks associated with virtually any dental procedure. I consent to allow the doctor to examine my oral conditions. Based on the results of the examination a diagnosis and proposed treatment plan and options including consequences of no treatment will be explained to me at which time it will be my choice to proceed.

I have read a copy of this office's Notice of Privacy Practices

Signature _____ Date _____

Changes in Health _____ Date _____

Changes in Health _____ Date _____

Changes in Health _____ Date _____

Changes in Health _____ Date _____

CASTLE ROCK
DENTAL HEALTH
2 OAKWOOD PARK PLAZA STE 206 | CASTLE ROCK CO, 80104 | (303) 663-9600

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

CASTLE ROCK
DENTAL HEALTH
2 OAKWOOD PARK PLAZA STE 206 | CASTLE ROCK CO, 80104 | (303) 663-9600

Written Financial Policy

Thank you for choosing Castle Rock Dental Health. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa®, MasterCard®, Discover®, American Express®, or CareCredit® Healthcare Credit Card
- We offer an annual In-House Membership Program for patients with no insurance, which provides routine preventive care and discounted dental treatment as a benefit of membership.
- We offer a 10% courtesy discount to patients with no insurance that pay for their treatment at the time services are rendered. Payment must be made with cash or check and cannot be combined with the discount provided through our In-House Membership Plan.
- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
    - Allows you to pay over a period of time that best works with your budget
    - No annual fees or pre-payment penalties

Please note:

- Castle Rock Dental Health requires payment at time of completion of each visit.
- For plans requiring multiple appointments, alternative payment arrangements may be provided.
- For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]
- A fee of $75 per hour appointment is charged for patients who miss or cancel without 48-hour notice.
- Castle Rock Dental Health charges $30 for returned checks.
- Patient further agrees that should unpaid monies remain owed, customer is responsible for all collections fees and/or attorney fees incurred in the process of collecting the unpaid balance. Not limited to allowable interest, but also any awarded court costs as well.

We are here to provide you with the dental care you want and need.

By signing this you agree to these terms and conditions.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

CASTLE ROCK
DENTAL HEALTH
2 OAKWOOD PARK PLAZA STE 206 | CASTLE ROCK CO, 80104 | (303) 663-9600

Prescription Drug Monitoring Notification

By signing this form, you confirm that you have been notified that if you receive a prescription for a controlled substance (narcotic drug) from our office and fill that prescription at a pharmacy in Colorado, certain identifying prescription information, including the name of the patient, will be entered into a secure database maintained by Colorado's prescription drug monitoring program. State law requires pharmacies to report information about controlled substance prescriptions filled to the prescription drug monitoring database.

This database is used to help prevent inappropriate uses of controlled substances—like fraud and diversion. The prescription drug monitoring program database contains records related to controlled substances (narcotic drugs like painkillers, muscle relaxants and steroids). It does not contain records about other prescription drugs like antibiotics, antidepressants or any other category of prescription medication.

Only authorized individuals, like healthcare personnel that prescribe controlled substances and law enforcement under very limited circumstances can access the database and only for tightly defined uses. As long as you are using controlled drugs appropriately, there shouldn't be reason for concern. If you do not want your information in the database, please ask your dentist to prescribe a non-narcotic drug for you.

More information about Colorado's prescription drug monitoring program, including copies of individual prescription drug records stored in the database, can be obtained from the Colorado State Department of Regulatory Agencies by calling 303/894-5957 or by visiting:

http://www.dora.state.co.us/pharmacy/pdmp/consumers.htm

I have read and understand this notification.

Date _____ Signature of patient/guardian _____

If this notification is signed by a personal representative/guardian on behalf of the patient, please complete the following:

Personal Representative Name: _____

Relationship to Patient:_____