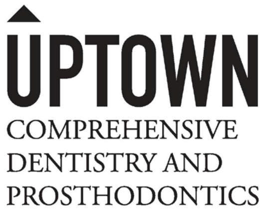


NEW PATIENT INFORMATION

Welcome to our practice!

Thank you for trusting us with your dental care. We promise to provide you with the finest care available. If you have any questions, please do not hesitate to ask us.

Patient Information

Name: ______________________ Date of Birth: ____________ Cell Phone: ______________

Address: ______________________ City: ______________ State: _____ Zip Code: __________

Home Phone: ____________ Social Security #: ______________ Email: ______________________

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

How would you like to confirm your appointment? ☐ Cell Phone ☐ Home Phone ☐ Email

Patient/Parent's Employer: ______________________________ Work Phone: ______________

Spouse or Parent's Name: ______________ Employer: ______________ Work Phone: ______________

Whom may we thank for referring you? ______________________________________

Emergency Contact: ______________________________ Phone: ______________

Person Responsible for Account

Name: ______________________________ Relationship to Patient: ______________

Address: ______________________ City: ______________ State: _____ Zip Code: __________

Phone: ______________________ Date of Birth: ____________ Driver's License #: ______________

Employer: ______________ Work Phone: ______________ Currently a patient in our office? ☐ Yes ☐ No

Primary Insurance Information

Name of Insured: ______________________________

Relationship to Patient: __________ Date of Birth: ________

Social Security #: __________ Subscriber ID #: __________

Employer: ______________ Date Employed: ________

Employer Address: ______________________________

City: ______________ State: _____ Zip Code: ________

Work Phone: ______________________________

Insurance Company: ______________________________

Insurance Company Address: ______________________

City: ______________ State: _____ Zip Code: ________

Group #: __________ How much is your deductible? ________

Max. Annual Benefit: ______ How much have you used? ______

Secondary Insurance Information

Name of Insured: ______________________________

Relationship to Patient: __________ Date of Birth: ________

Social Security #: __________ Subscriber ID #: __________

Employer: ______________ Date Employed: ________

Employer Address: ______________________________

City: ______________ State: _____ Zip Code: ________

Work Phone: ______________________________

Insurance Company: ______________________________

Insurance Company Address: ______________________

City: ______________ State: _____ Zip Code: ________

Group #: __________ How much is your deductible? ________

Max. Annual Benefit: ______ How much have you used? ______

-----CONTINUED ON BACK-----

Dental History

Reason for today's visit: ____________________

Former Dentist: ____________________ Date of last visit: __________ Date of last x-rays: __________

Dentist Address: ____________________ City: __________ State: ______ Zip Code: __________

Check if you have had any of the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to heat	☐ Sensitivity to cold
☐ Bleeding Gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets	☐ Sensitivity when biting
☐ Clicking or popping jaw	☐ Food collection between teeth	☐ Periodontal Treatment	☐ Sores or growths in your mouth

How often do you brush? ____________________ How often do you floss? ____________________

Medical History

Physician's Name: ____________________ Date of last visit: ____________________

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe: ____________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates: ____________________

Women: Are you pregnant? ☐ Yes ☐ No Are you Nursing ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Check if you have had any of the following:

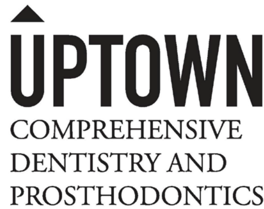
☐ AIDS	☐ Chemotherapy	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Stroke
☐ Anemia	☐ Circulatory Problems	☐ Heart Problems	☐ Nervous Problems	☐ Swelling of Feet/Ankles
☐ Arthritis, rheumatism	☐ Cortisone Treatments	Describe: __________	☐ Pacemaker	☐ Thyroid Problems
☐ Artificial Heart Valves	☐ Cough, Persistent	☐ Hemophilia	☐ Psychiatric Care	☐ Tobacco Habit
☐ Artificial Joint s	☐ Cough up Blood	☐ Hepatitis	☐ Radiation Treatment	☐ Tonsillitis
☐ Asthma	☐ Diabetes	☐ High Blood Pressure	☐ Respiratory Disease	☐ Tuberculosis
☐ Back Problems	☐ Epilepsy	☐ HIV Positive	☐ Rheumatic Fever	☐ Ulcer
☐ Blood Disease	☐ Fainting	☐ Jaw Pain	☐ Scarlet Fever	☐ Venereal Disease
☐ Cancer	☐ Glaucoma	☐ Kidney Disease	☐ Shortness of Breath	
☐ Chemical Dependency	☐ Headaches	☐ Liver Disease	☐ Skin Rash	

Medications	Allergies
____________________	____________________
____________________	____________________
____________________	____________________

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

____

Patient or Parent Signature | Relationship to Patient | Date



NOTICE OF PRIVACY PRACTICES

John Chen, DDS
6240 South Main Street Suite 215, Aurora, CO 80016
Phone: 303-627-5755 • Fax: 303-627-5756 •

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

Federal and state law requries us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we ill change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the beginning of this notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.
Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assesment and improvement activities, reviewing the competence or qualificiations of health care professionsals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement actvities, review the competence or qualifactions of health care professionals, or detect or prevent health care fraud and abuse.
On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot sue or disclose your health information for any reason except those described in this notice.
To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present , or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemails, postcards, or letters).
Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.
Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;

- In response to court and administrative orders and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To an organ procurement organizations;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institution regarding inmates; and
- As authorized by state worker's compensation laws.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access y sending us a letter to the address at the top of this notice. If you request copies, we may charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may—but are not required to—prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the beginning of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the beginning of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions but if we do, we will abide by our agreement (except in an emergency). Any other agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the beginning of this notice.

If you believe that :

- We may have violated your privacy rights;
- We made a decision about access to your health information incorrectly;
- Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect; or
- We should communicate with you by alternative means or at alternative locations;

you may contact us using the information listed at the beginning of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We will support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Acknowledgement of Receipt of Privacy Practices Notice

I, ____________________________________ acknowledge that I have received a Notice of Privacy Practices from the above named practice.

____

Patient/Parent Signature Date

____

Parent/Personal Representative's Name Relationship to Patient

UPTOWN
COMPREHENSIVE
DENTISTRY AND
PROSTHODONTICS

FINANCIAL & INSURANCE POLICIES

Financial Policy

We are pleased to offer these financial services:

- If you have insurance coverage and Dr. Chen is a provider for that company, we will file the claim with the company electronically. Electronic filing generally receives faster service and payment than paper claims.
- We will follow up on past due insurance claims for a period of 60 days.
- If treatment requires pre-authorization from your insurance company, we will prepare and file it.
- If you have an insurance plan for which Dr. Chen is a provider and that plan offers you a discounted fee, we will accept that fee.

Generally, the services provided by our office are routine. We will perform an initial examination and provide you with a review of the examination. If we find that you are in excellent dental health, we will ask to see you again in 3-6 months for a routine check-up and cleaning. At the end of your initial visit, as well as at the end of routine visits, payment will be due for your portion of the treatment provided.

At some point, your dental care may dictate complicated procedure(s). If this occurs, you will be presented with a treatment plan and estimate which will outline the suggested treatment, costs, estimated insurance portion (if applicable) and a payment schedule. The treatment plan will be explained and you will be asked if you wish to proceed with the plan. If you decide to proceed, you will be asked to approve the plan and abide by the payment schedule and financial agreement therein.

It is important to remember that you are responsible for all fees incurred in this office. This means that if the insurance company does not pay for any part of the amount expected of them, you will be required to pay the unpaid portion. It will be your responsibility to follow up with your company in the event they indicate coverage has been terminated or if other discrepancies occur. Statements may be sent monthly. They show your balance as well as an insurance balance, if applicable. If your treatment involves a payment schedule, you will receive monthly statements.

If you have any questions or concerns regarding Dr. Chen's financial policy, please contact a member of our staff.

I acknowledge that I have read this financial policy and agree to abide by it.

____

Patient Signature Date

Insurance Policy

We are committed to providing you with the best possible care. This information is designed to guide you through the rapidly changing world of dentistry and insurance plans. Please read carefully and sign at the bottom of the page indicating your understanding and acceptance of our policies and procedures.

If you have dental insurance, we can provide you with a receipt for you to submit or as a courtesy submit your claim for you. Our receipt is suitable for your insurance company. We will have you pay for any deductibles and co-pays required at the time of service. **Payment is due at the time of service unless payment arrangements have been made and approved in advance.**

You must realize that:

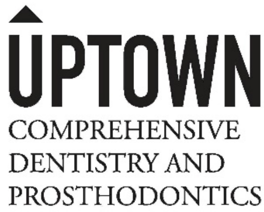
- Your insurance is a contract between you, your employer, and the insurance company. **We are not included in your contract.**
- **Not all services are covered by all insurance policies**. Some companies select certain services that they will not cover.
- The "Usual and Customary Charges" that may be quoted by your insurance company are charges that have been determined and set by your insurance company. They do not necessarily reflect our fees.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While filing your insurance claims for our patients is a courtesy that was extended, **all charges are your responsibility from the date service is rendered**. We do realize that there are times that a temporary financial problem may affect your payment of your account. In that case, please contact our financial advisor for assistance so that we may be able to set up payment options for you. If you have any questions, feel free to ask us. We will be glad to help.

Regardless of any insurance coverage that I may have, I agree that it is my responsibility to pay my balance and will pay any balance due.

____

Patient Signature Date



CONSENT TO DENTAL PHOTOGRAPHY

John Chen, DDS
6240 South Main Street Suite 215, Aurora, CO 80016
Phone: 303-627-5755 • Fax: 303-627-5756 •

Dental photography is a powerful tool. It allows our office to correctly communicate treatment with our patients and referring colleagues. I, ________________________________ (Patient), authorize Dr. John Chen or staff of Uptown Comprehensive Dentistry and Prosthodontics, to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

- *Communication with referring dental/medical offices*
- *Dental Records*
- *Dental Research*
- *Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books*
- *Marketing material, including websites, social media and printed materials for patient education*

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

____

Patient/Parent Signature Date

____

Parent/Personal Representative's Name Relationship to Patient