HIGHLANDS RANCH PERIO

Patient Information

Patient Name _____

Mailing Address _____ **City**_____ **State** _____**Zip**_____

Home Phone _____ **Cell Phone**_____

Work Phone_____ **Email** _____

Birth Date ____/ ___/_____ Age_____ **Sex:** Male Female Other:_____

Social Security _____ Driver's License _____

Occupation _____ Business _____

If married, spouse' name _____ If child, parent's name _____

Emergency Contact _____ **Phone Number** _____

Address _____ **Relationship to patient**_____

How did you hear about our office? _____

Do you have any specific dental concerns? _____

Dental Insurance Information

Policy Holder's Name _____ Name of Employer _____

Member ID or SSN _____ Birth Date ___/____/_____

Insurance Company_____ Group # _____

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes.

Patient Signature (parent if minor)_____ Date_____

HIGHLANDS RANCH PERIO

Medical History

Patient Name_____ Birth Date_____

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.

*Physician's Name*_____ *Physician's Phone #*_____

Are you under a physician's care now?	☐ Yes	☐ No	If yes please explain: _____
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes please explain: _____
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes please explain: _____
Do you take, or have you taken Oral Bisphosphonate Drugs	☐ Yes	☐ No	If yes please explain: _____
Are you on a special diet?	☐ Yes	☐ No	If yes please explain: _____
Do you use tobacco?	☐ Yes	☐ No	If yes please explain: _____
Do you use controlled substances?	☐ Yes	☐ No	

Women, are you: Pregnant or trying to get pregnant? ☐Yes ☐No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

Are you allergic to any of the following?

☐Asprin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Anesthetics

☐Other If yes, please explain: _____

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

Aids/HIV Positive	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Congential Heart Disorder	☐ Yes ☐ No	Heart Pace Maker	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No		☐ Yes ☐ No

Please list any condition not listed above:_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND FOR WHAT CONDITION

Over the counter medications and dosage: ***Prescribed RX medications and dosage:***

HIGHLANDS RANCH PERIO

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE_____

IN HIGHLANDS RANCH PERIO
DR. MIKE NOROUZINIA
9090 S. RIDGELINE BLVD. #225
HIGHLANDS RANCH, CO 80129

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

2. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

3. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my periodontist, hygienist, and dental office staff.

4. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____

Patient or Guardian Name Dat

IN HIGHLANDS RANCH PERIO

DR. MIKE NOROUZINIA
9090 S. RIDGELINE BLVD. #225
HIGHLANDS RANCH, CO 80129

Financial Policy

Insurance: As a courtesy to our patients, we do bill primary insurance. Please bear in mind that there are many different plans and policies. **Your insurance is a contract between you and your insurance company**. Some, and perhaps all, of the services provided may not be covered by your insurance company, in which case you will be responsible for the charges for these services. Although we gather as much information as possible regarding your insurance, it is ultimately **your responsibility to know which services your insurance policy covers**. Insurance is designed to pay only a portion of the cost of your dental needs. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates or benefits.

Payment: Payment is due when service is provided. If you have insurance we will collect from you the amount estimated as your initial responsibility. Any amount not paid by your insurance, in accordance with your policy, is your responsibility and due upon receipt of a statement from our office. Balances carried over 90 days are considered delinquent and will be subject to an 12% finance charge.
Delinquent accounts will be turned over for collection and you will be held responsible for collection and/or legal fees. We accept cash, checks, MasterCard, Visa and American Express. We also offer extended financing through CareCredit and Lending Club.

Missed Appointments: If you cancel your appointment with less than 48hr notice, you will have to place a 20% nonrefundable deposit for your next appointment. If you cancel that appointment with less than 48hrs notice you will be placed on a short call list to schedule future appointments. If you cancel your third appointment, you will be dismissed from the practice.

I have read, understand and agree to this financial policy.

_____

Signature of Patient, Parent or Guardian **Date**

_____

Signature of Patient, Parent or Guardian

IN HIGHLANDS RANCH PERIO

DR. MIKE NOROUZINIA
9090 S. RIDGELINE BLVD. #225
HIGHLANDS RANCH, CO 80129

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble.

Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay. Should your coverage be less than anticipated, you will be responsible for the difference.

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. Better terms for dental insurance may be "dental assistance" or "dental benefits."

Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company.

I have read and understand the above and understand it is my responsibility to inform the office of any changes in my coverage.

Print Patient Name	Patient Signature	Date

IN HIGHLANDS RANCH PERIO

DR. MIKE NOROUZINIA
9090 S. RIDGELINE BLVD. #225
HIGHLANDS RANCH, CO 80129

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I understand that I have certain rights to privacy regarding my protected health information. These rights are given me under the Health Insurance Portability and Accountability Act of 1996. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment for services rendered.
- The day-to-day healthcare operations of our practice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations. Any request for restriction must be made in writing. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I acknowledge that I have received the Notice of Privacy Practices from Highlands Ranch Periodontics. In addition to the individuals, professionals, agencies, etc. listed therein, I authorize the release of my private, protected health information to the following: (Please name the person ONLY if you agree to the disclosure):

I, _____, have received a copy of this office's 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

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement
□ Other (Please specify)