WARD ROAD DENTAL

a David Eaton Family Practice

Ward Road Dental
5610 Ward Rd., #120
Arvada, CO 80002
303-420-4001
wardroaddental.com

PATIENT INFORMATION

Name _____ (Last Name) _____ (First Name) _____ (MI) Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Email _____

Sex M F Age _____ Date of Birth _____ Single Married Separated Divorced

Patient Employeed By _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Business Phone _____ Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Mobile Phone _____ Email _____

PRIMARY INSURANCE

Person responsible for account _____ (Last Name) _____ (First Name) _____ (MI)

Relation to Patient _____ Date of Birth _____ Soc. Sec. # _____

Address *(if different from Patient)* _____ City _____ State _____ Zip _____

Home Phone _____ Mobile _____ Email _____

Person Employeed By _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Business Phone _____ Business Email _____

Insurance Company _____ Insurance Phone _____

Insurance Email _____ Subscriber # _____

Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is the Patient covered by additional insurance? Yes No Subscriber Name _____

Relation to Patient _____ Date of Birth _____ Soc. Sec. # _____

Address *(if different from Patient)* _____ City _____ State _____ Zip _____

Home Phone _____ Mobile _____ Email _____

Subscriber Employeed By _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Business Phone _____ Business Email _____

Insurance Company _____ Insurance Phone _____

Insurance Email _____ Subscriber # _____

Name of other dependents under this plan _____

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DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Dentist Address _____

Dentist Email _____ City _____ State _____ Zip _____

Dentist Phone _____ Date of last dental care _____ Date of last x-rays _____

Check (✓) if you have had any problems with any of the following:

___ Bad Breath	___ Food collection between teeth	___ Periodontal treatment	___ Sensitive to sweets
___ Bleeding Gums	___ Grinding or clenching teeth	___ Sensitive to cold	___ Sensitive when biting
___ Clicking or popping of jaws	___ Loose teeth or broken fillings	___ Sensitive to hot	___ Sores or growth in mouth

How often to do you brush? _____

How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ___ Yes ___ No

Other information about your dental health or previous treatment? _____

MEDICAL HISTORY

Physician's Name _____ Physician's Phone _____ Date of last visit _____

Have you had any serious illnesses or operations? ___ Yes ___ No If Yes, please describe: _____

Are you currently under physician care? ___ Yes ___ No If Yes, please describe: _____

Have you ever had a blood transfusion? ___ Yes ___ No If Yes, approx. dates? _____

Have you ever taken Fen - Phen / Redux ___ Yes ___ No

Women: Are you pregnant? ___ Yes ___ No Nursing? ___ Yes ___ No Taking birth control pills? ___ Yes ___ No

Check (✓) if you have had any problems with any of the following:

___ AIDS/HIV Positive	___ Cortisone treatments	___ High blood pressure	___ Shortness of breath
___ Acid Reflux	___ Cough persistent	___ Jaw pain	___ Skin rash
___ Anaphylaxis	___ Cough up blood	___ Kidney disease or malfunction	___ Spina bifida
___ Anemia	___ Diabetes	___ Liver disease	___ Stroke
___ Arthritis, Rheumatism	___ Epilepsy	___ Material allergy	___ Surgical implant
___ Artificial heart valves	___ Fainting	(latex, wool, metal, chemicals)	___ Swelling of feet or ankles
___ Artificial joints	___ Food allergies	___ Mitral valve prolapsed	___ Thyroid disease / malfunction
___ Asthma	___ Glaucoma	___ Nervous problems	___ Tobacco habit
___ Atopic (allergic prone)	___ Headaches	___ Pacemaker / heart surgery	___ Tonsillitis
___ Back problems	___ Heart murmur	___ Psychiatric care	___ Tuberculosis
___ Blood disease	___ Heart problems	___ Rapid weight gain or loss	___ Ulcer / Colitis
___ Cancer	Describe: _____	___ Radiation treatment	___ Venereal disease
___ Chemical dependency	___ Hemophilia/abnormal bleeding	___ Respiratory disease	
___ Chemotherapy	___ Herpes	___ Rheumatic / Scarlet fever	
___ Circulatory problems	___ Hepatitis	___ Shingles	

Is the Patient currently taking any medications? If Yes, list all: _____

Does the Patient have drug allergies? If Yes, list all: _____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist 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.

_____ _____

Signature Date

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HANDLE ME WITH CARE

____ I gag easily.

____ I feel out of control when I am lying down in the dental chair.

____ I have not been to the dentist for a long time and I feel uncomfortable about what they will say or think about my teeth and my dental hygiene.

____ I know I have bad habits that are causing harm to my dental health. I am afraid I might not be able to break them.

____ Pain relief is a top priority to me

____ I don't like shots, or I've had a bad reaction to shots.

____ Please tell me what I need to know about my mouth so I can make an informed decision.

____ My teeth are very sensitive.

____ I don't like the sound of that tool that makes the picking and scraping noise.

____ I don't like cotton in my mouth.

____ I hate the noise of the drill.

____ I don't like the dental office smells.

____ Please respect my time. I don't want to be left sitting in the reception area.

____ I want to know the cost up front. No money surprises, please.

____ I have difficulty listening and remembering what I hear while sitting in the dental chair.

____ I have health problems and questions that we need to discuss.

____ I don't like being left alone in the treatment area.

____ I have problems with my back.

____ I don't like the chair tipped back too far.

____ I do not like to see dental instruments.

____ I need to talk to you first, without sitting in the dental chair.

____ Other concerns I would like to talk about (Please specify):

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GENERAL CONSENT

Thank you for choosing Ward Road Dental for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing 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 confidence in social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction.** Dental materials and medications may trigger allergic or sensitive reactions.
2. **Long-term numbness (parathesia).** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or jaw joint tenderness.** Holding one's mouth open can result in a muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ (jaw joint) disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding.**
5. **Swallowing or inhaling small objects.**
6. **Tooth damage may be severe enough to require endodontic treatment (root canal treatment).**

While we will do our best to keep you comfortable and achieve clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned, such as unforeseen changes in treatment and additional expenses may be incurred. We will do our best to assure that it does. Please feel free to ask questions in regards to all dental procedures that are recommended to you.

I have read and understand the statement on this page.

Patient's Signature	Date
Parent's Signature (if minor patient)	Date

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FINANCIAL POLICY

At Ward Road Dental, our goal is to provide the highest dental care in a relaxed, comfortable, and friendly environment. Before proceeding with any treatment, all fees and financial arragements will be discussed with you; and all your questions will be answered. Dental treatment is an important decision, so we take the time to ensure that you understand exactly what is being done, the benefits, and the risks. Please take a moment to familiarize yourself with our financial policy.

INSURANCE

While we are contracted with some PPO plans, we accept all benefits as an out-of-network provider. Ultimately, you are responsible for payment of all fees for dental care rendered by our office. As a courtesy, our office will do insurance filing on your behalf.

METHODS OF PAYMENT

Payment is expected at the time of service. We do accept benefit assignment, but the patient portion is due at the time of service. How would you like to pay for your visit? Please check one:

___ Cash ___ Check ___ Credit Card ___ Debit Card ___ CareCredit Card

RESIN RESTORATIONS CONSENT (FILLINGS)

If I need restorations (fillings) on one or more of my posterior (molar or bicuspid) teeth, I consent to the use of resin (tooth-colored) filling material. I am aware that my insurance may only pay the amalgam (silver) allowance for posterior teeth or may only charge a co-payment for this service. I agree to pay the additional amount for resin fillings.

I have read and understand the financial policy of Ward Road Dental and David Eaton, DDS.

Signature of Patient, Parent, or Guardian

Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

David Eaton, DDS PC

You May Refuse to Sign This Acknowledgement

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)

_____

_____

_____

_____

_____

_____

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NOTICE OF PRIVACY PRACTICES

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

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required 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 that are described 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 changes are permitted by applicable law. We reserve the 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 will 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 end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provided to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health of safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security actives. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

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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 obtain a form to request access by suing the contact information listed at the end of this Notice. We will charge you a reasonable cost-base fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of the Notice. If you request copies, we will charge you **$1.00** for each page, **$20.00** per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 will prepare a summary of an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of you 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.)

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.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled 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 the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may 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 Human Services upon request.

We 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.

Contact Officer: _____

Telephone: _____ **Fax:** _____

E-Mail: _____

Address: _____