MOUNTAIN VIEW DENTAL CARE
PATIENT INFORMATION

PATIENT NAME_____ PHONE _____

ADDRESS _____

CITY_____STATE _____ZIP_____

EMAIL ADDRESS _____

SOCIAL SECURITY #_____DATE OF BIRTH_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

INSURANCE INFORMATION

DENTAL INS COMPANY_____

SUBSCRIBER/POLICY HOLDER NAME _____ DATE OF BIRTH _____

MEMBER ID/SOCIAL SECURITY # _____ GROUP #_____

EMPLOYER _____ RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE INFORMATION

DENTAL INS COMPANY_____

SUBSCRIBER/POLICY HOLDER NAME _____ DATE OF BIRTH _____

MEMBER ID/SOCIAL SECURITY # _____GROUP #_____

EMPLOYER _____ RELATIONSHIP TO PATIENT_____

EMERGENCY CONTACTINFORMATION

NAME _____ PHONE_____

RELATIONSHIP TO PATIENT _____

TREATMENT AUTHORIZATION AND CONSENT

I understand that the above information is necessary to provide the undersigned with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provide or agency who may release such information to you. I will notify the dentist or hygienist of any change in my health or medication.
The undersigned authorizes Mountain View Dental Care to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs and to perform treatment, provide medications, and therapy that may be indicated. I understand that the use of anesthetic agents embodies a certain risk.
Mountain View Dental Care may use my health care information to obtain payment for services and to determine insurance benefits from the above-named insurance company(ies). I understand that my dental insurance is a contract between myself and the insurance carrier, and not between the insurance carrier and Doctor, and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I authorize the use of my signature on all insurance submissions and I assign all insurance benefits to Mountain View Dental Care. Any payments received by this office from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any balances 60 days past due. If it becomes necessary to forward my account to a collection agency, in addition to the amount owed I will be responsible for the cost of collection. If it becomes a legal cost then I will be responsible for all reasonable court costs and attorney fees.

Signature _____ Date _____

Print Name _____

If applicable: Parent/Guardian Signature_____ Date_____

MOUNTAIN VIEW DENTAL CARE
NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDMENT

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.
At our practice, we have always kept your health information secure and confidential. A new law requires us to continue to maintain your privacy, to give you this notice and to follow the terms of this notice.
The law permits us to use or disclose your health information for payment of services. For example, we may send a report of your progress to your insurance company.
We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
We may use your information to contact you. For example, we may send a newsletter or other information. We may also call and remind you of your appointments. If you are not at home, we may leave this information on your answering machine or with a person that answers the phone.
In an emergency we may disclose your health information to a family member or another individual responsible for your care.
We may release some or all of your health information when required by law.
If this practice is sold, your information will become the property of the new owner.
Except as described above, this practice will not use or disclose your health information.
You have the right to know the uses and disclosures we make with your health information beyond normal uses.
As we will need to contact you from time to time, we will use whatever address or phone number we have on records.
You have the right to transfer copies of your health information to another practice. We will mail your files for you once the appropriate release is signed. You have the right to see and receive a copy of your health information with a few exceptions. Give us a written request regarding the information that you wish to see.
If you also want a copy of your records, we may charge a reasonable fee for the copies.
You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a written statement in your files, please give it to us in writing. We may or may not make the changes that you request but will be happy to include your request and statement in your file. If we agree to the amendment or change, we will not remove or alter earlier documents we will just add new information.
You have a right to receive a copy of this notice. If we change any of the details of this notice, we will notify you in writing.
You may file a complaint with the Department of Health and Human Services,
200 Independence Ave. S.W. Room 509R, Washington, DC 20201. You will not be retaliated against for making a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at 303-768-8977.
This notice goes into effect as of April 15, 2003.

Please sign acknowledgement. Please request a copy for your records this copy for your records.

I have read the Mountain View Dental Care Privacy Practices.

Signature_____ **Date** _____

Print Name _____

If signing as a parent or guardian please print patient's name _____

125 Inverness Drive East, Suite 310, Englewood, Colorado 80112
Phone: 303-768-8977 Fax: 303-862-4803 mountainviewdentalcare@gmail.com

MOUNTAIN VIEW DENTAL CARE
HEALTH HISTORY INFORMATION

PATIENT NAME _____ **DATE** _____

Please complete this entire questionnaire. This will provide your care team with important information about your health. All answers are strictly confidential. Any changes from previous visits will be made in your medical record.

MEDICATIONS

Please list any medications you are currently taking _____

_____

Approximate date of last dental cleaning _____Are you currently pregnant or nursing? _____

Tobacco use? If so, what kind and how much? _____

Any unusual reactions to dental injections? _____

Please list any current surgeries (within last 5 yrs.) _____

Do you have any apprehension concerning dental treatment? ☐ Mild ☐ Moderate ☐ Severe

ALLERGIES

Are you allergic to any of the following?

- ☐ Acetaminophen (Tylenol)
- ☐ Anesthetic (Dental)
- ☐ Aspirin
- ☐ Clindamycin
- ☐ Codeine
- ☐ Epinephrine
- ☐ Erythromycin
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Latex
- ☐ Penicillin
- ☐ Sedatives
- ☐ Sulfa
- ☐ Tetracycline
- ☐ No known allergies

Other _____

MEDICAL CONDITIONS

Do you have any of the following medical conditions?

- ☐ Abnormal Bleeding
- ☐ Acid Reflux-Gerd
- ☐ ADHD
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cold Sores
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Hearing Aids
- ☐ Hearing Problems
- ☐ Heart Attack
- ☐ Heart Mitral Valve Replacement/Repair
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Migraines
- ☐ Nose Bleeds (Frequent)
- ☐ Osteoporosis
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Emphysema/COPD

Other _____

To the best of my knowledge, all of the answers on this form are true and correct. If I ever have any change in my health, I will inform the doctor and/or hygienist at my next appointment.

SIGNATURE _____ DATE_____

Reviewed by _____ *Date* _____

MOUNTAIN VIEW DENTAL CARE
CANCELLATION POLICY

Your appointments and well-being are very important to us.

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

If you must cancel your appointment, we respectfully request a 48hour notice. **Missed appointments, or appointments cancelled without a 48hour notice, will incur a fee of $75.00**

If you need to cancel your appointment, please call us at 303-768-8977 between the hours of 8am and 4pm. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

Signature _____ Date _____

Print Name _____

125 Inverness Drive East, Suite 310, Englewood, Colorado 80112
Phone: 303-768-8977 Fax: 303-862-4803 mountainviewdentalcare@gmail.com

MOUNTAIN VIEW DENTAL CARE
RELEASE OF DENTAL RECORDS

Patients Name_____

Address_____

Phone_____ Date of Birth _____

I hereby authorize the following facility to provide copies of my dental records with respect to any dental care and treatment that I have received.

TO / FROM (please circle)

Mountain View Dental Care

125 Inverness Dr. E. Ste. 310

Englewood CO 80112

Phone 303-768-8977

Fax 303-862-4803

Email – mountainviewdentalcare@gmail.com

TO / FROM (please circle)

Name _____

Address_____

_____

Phone _____

Fax _____

Email _____

I understand that the specific type of information to be disclosed may include a detailed report of examinations, treatment provided, x-rays and all other records which pertain to me. This consent is effective until such date as I can cancel this consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

_____ _____ _____

Patient's signature Date Patient's Name (please print)

_____ _____ _____

Legal Guardian or representative signature Date Relationship to patient

Date records sent _____ Initials_____