DATE_____ BIRTHDATE_____

NAME_____

SSN _____

Denver Smiles
Personalized & Comfortable

8015 W ALAMEDA AVE STE 115 LAKEWOOD CO 80226
303.623.4444 DENVERSMILES.COM

ABOUT YOU

ADDRESS_____UNIT/APT_____ HOME PHONE_____
CITY _____ ZIP _____ CELL PHONE _____
_____ MALE _____ FEMALE | _____ MINOR _____ SINGLE _____ MARRIED _____DIVORCED
EMAIL_____
EMPLOYER _____ BUSINESS PHONE_____
EMPLOYER ADDRESS_____ OCCUPATION _____
EMERGENCY CONTACT_____ PHONE_____
WHOM SHOULD WE THANK FOR REFERRING YOU? _____

DENTAL INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT _____
RELATIONSHIP TO PATIENT_____ BIRTH DATE _____ SSN _____
ADDRESS_____ HOME PHONE _____
CITY_____ STATE _____ ZIP_____
RESPONSIBLE PARTY EMPLOYER_____ BUSINESS PHONE _____
INSURANCE COMPANY_____ SUBSCRIBER ID_____
INSURANCE COMPANY ADDRESS_____
INSURANCE COMPANY PHONE NUMBER_____ PAYOR ID_____

DENTAL HISTORY

FORMER DENTIST_____ DATE OF LAST XRAYS_____
CITY/STATE_____ HOW OFTEN YOU FLOSS_____
DATE OF LAST DENTAL VISIT_____ HOW OFTEN YOU BRUSH_____
PLEASE CHECK ALL THAT APPLY:

_____ BAD BREATH	_____ JAW/HEAD/NECK INJURIES	_____ NAIL BITING	_____ SENSITIVITY TO HEAT
_____ BLEEDING GUMS	_____ JAW CLICKING OR PAIN	_____ ORTHODONTICS	_____ SENSITIVITY TO SWEETS
_____ BLISTERS ON LIPS OR MOUTH	_____ LIP OR CHEEK BITING	_____ PAIN AROUND EAR	_____ SENSITIVITY WHEN BITING
_____ FREQUENT HEADACHES	_____ LOOSE TEETH/BROKEN FILLINGS	_____ PERIODONTAL TREATMENT	_____ TOOTH PAIN
_____ GRINDING TEETH	_____ DENTAL ANXIETY OR FEAR	_____ SENSITIVITY TO COLD	_____ DRY MOUTH

INTERESTED IN ADDITIONAL PREVENTIVE SERVICES? (fluoride, sealants, reducing sensitivity, etc.) ____YES ____NO
ADDITIONAL IMPORTANT DENTAL HISTORY _____
_____

MEDICAL HISTORY

PHYSICAN'S NAME_____ DATE LAST VISITED_____

1. CURRENTLY UNDER MEDICAL TREATMENT? __ YES __ NO 2. ANY SERIOUS ILLNESSES/OPERATIONS? __ YES __ NO

IF YES, PLEASE DESCRIBE ILLNESS/OPERATION_____

_____

3. CURRENTLY TAKING MEDICATIONS? __ YES __ NO IF YES, PLEASE LIST MEDICATIONS_____

_____

_____

4. USE TOBACCO? __ YES __ NO 5. CONSUME ALCOHOL? __ YES __ NO 6. RECREATIONAL DRUGS? __ YES __ NO

7. WEAR CONTACT LENSES? __ YES __ NO 8. ALLERGIC REATIONS TO THE FOLLOWING? (CHECK ALL THAT APPLY)

____ LOCAL ANESTHETICS	____ PENICILLIN OR OTHER ANTIBIOTICS	____ SULFA DRUGS	____ BARBITURATES (SLEEPING PILLS)
____ SEDATIVES	____ IODINE	____ ASPIRIN	

ANY OTHER ALLERGIES? _____

9. (**WOMEN ONLY**) PREGNANT? __ YES __ NO NURSING? __ YES __ NO ORAL CONTRACEPTIVES?__ YES __ NO

10. DIET/NUTRITION: VITAMINS? __ YES __ NO DRINK SODA? __ YES __ NO # OF MEALS/SNACKS PER DAY? _____

11. MEDICAL CONDITIONS (CHECK ALL THAT APPLY)

_____ AIDS	_____ CONGENITAL HEART PROBLEMS	_____HIV POSITIVE	_____ SCARLET FEVER
_____ ANEMIA	_____ CORTISONE TREATMENTS	_____JAUNDICE	_____ SHORTNESS OF BREATH
_____ARTHRITIS, RHEUMATISM	_____ COUGH (PERSISTANT OR BLOODY)	_____ JAW PAIN	_____ SINUS PROBLEMS
			_____ SLEEP APNEA
_____ ARTIFICIAL HEART VALVE	_____ DIABETES	_____ LATEX SENSITIVITY	_____ SKIN RASH
_____ ARTIFICIAL JOINTS	_____ EMPHYSEMA	_____ KIDNEY DISEASE	_____ STROKE
_____ ASTHMA	_____ EPILEPSY	_____ LIVER DISEASE	_____ SWELLING OF FEET OR ANKLES
_____ BACK PROBLEMS	_____ FAINTING/DIZZINESS	_____ LOW BLOOD PRESSUE	_____ SWOLLEN NECK GLANDS
_____ BLEEDING ABNORMALLY W/ EXTRACTION OR SURGERY	_____ GLAUCOMA	_____ MITRAL VALVE PROLAPSE	_____ THROID PROBLEMS
_____ BLOOD DISEASE	_____ HEADACHES	_____ NERVOUS PROBLEMS	_____ TONSILITIS
_____ CANCER	_____ HEART MURMUR	_____ PACEMAKER	_____ TUBERCULOSIS
_____ CHEMICAL DEPENDENCY	_____ HEART PROBLEMS	_____ PSYCHIATRIC CARE	_____ TUMOR/GROWTH ON HEAD OR NECK
_____ CHEMOTHERAPY	_____ HEPATITIS TYPE ___	_____ RADIATION TREATMENT	_____ ULCER
_____ CHRONIC FATIGUE SYNDROME	_____ HERPES	_____ RESPIRATORY DISEASE	_____ VENEREAL DISEASE/ STD's
_____ CIRCULATORY PROBLEMS	_____ HIGH BLOOD PRESSURE	_____ RHEUMATIC FEVER	

OTHER IMPORTANT MEDICAL CONDITIONS: _____

_____

_____

_____

FINANCIAL POLICY AND AGREEMENT

The goal of Denver Smiles is to provide exceptional customer service and excellent dental care with both a professional and personal touch. We do not want finances to be an issue for our patients and would like to make certain that our financial policies and options are understood by our patients.

DENTAL INSURANCE: If you have dental insurance, as a courtesy to you, we will complete your insurance forms and submit them to your insurance carrier. We do ask that you provide us with all necessary and important information pertaining to your dental insurance. Failure to not provide necessary information may result in delayed claim processing and a request for payment in full may be made. We will do our best to assist you in understanding your dental benefits and understanding that insurance is just an estimate and not a guarantee of benefits. Your estimated copayment (the amount not covered by insurance) for treatment is due at the time of service. **Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is given an alternate benefit, you will be responsible for paying the full balance on the account at that time.** Please remember that your insurance coverage is a contract between you and your benefit carrier and/or your employer and your benefit carrier. Our office will not enter into a dispute with your insurance company over any claim, although we will assist in providing the necessary documentation your insurance company requests for settlement. If your insurance carrier denies coverage, or if we don't not otherwise receive payment within 60 days from the date services are rendered, the amount will then become due and payable by you.

PAYMENT OPTIONS: Cash, Check (returned check fee may apply), Visa, Mastercard, American Express, Discover, Care Credit and Lending Club.

PATIENT RESPONSIBILITY: I acknowledge my responsibility for payment of services rendered by Denver Smiles in accordance to the fees and terms. I understand my responsibility is not modified by whether any third party (dental insurance carrier) pays for all, part, or none of the charges. If the account is not paid within 30 days from my statement, a service fee will be applied to my account. If my account becomes delinquent, it may be forwarded to a third-party collection agency and I will be responsible for any and all additional legal fees/charges incurred to collect on my account.

ASSIGNMENT AND RELEASE: I authorize payments to be made to Denver Smiles/Bernard Slota DDS by my dental benefit carrier. I accept financial responsibility for all services not covered by insurance. I authorize release of any dental care information requested by my insurance company.

CANCELLATION POLICY: At Denver Smiles, we understand that we live in a busy world. We are committed to seeing our patients on time and respecting their time. Cancellations (less than 48 business hour notice), failed appointments, and late arrivals are disruptive to our schedule and our other patients. We request a 48-hour business hours notification for all cancellations or rescheduling of appointments. Cancellations and rescheduling of appointments must be made with office staff during normal business hours. Cancellations and rescheduling of appointments are not accepted by voicemail or email. There will be a $50-100 fee charged for broken appointments and late cancellations.

I acknowledge that I have received a copy of the financial policy, agreement, and cancellation policy for Denver Smiles. Bernard D Slota, DDS, reserves the right to change and/or update the policies states above and I will be offered a copy of the revised policy at my visit.

SIGNATURE AUTHORIZATION _____ DATE _____

CONSENT TO PERFORM DENTISTRY

I hereby and direct Dr Slota and/or dental personnel of his choice, to perform the following treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

- Cleaning of the teeth and the application of topical fluoride

- Treatment of the diseased or injured teeth with the dental restorations (fillings), crowns, and/or never treatment (root canals)
- Replacement of teeth with dental prosthesis
- Removal (extraction) of one or more teeth
- Treatment of diseased or injured oral tissue (hard and/or soft)
- Use sedative drugs in patients who cannot otherwise tolerate treatment
- Postponing or delaying treatment at this time

This treatment has been explained to me. Alternate methods of treatment, if any have been explained to me, as have the advantages, disadvantages and risks of each. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee either expressed or implied, as the result of the treatment or as to the cure.

I recognize that during the course of the treatment unforeseen circumstances may necessitate different procedures from discussed. I therefore authorize and request performance of any additional procedures that are deemed necessary or desirable to my oral health and wellbeing in the professional judgement of Dr Slota.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually every dental procedure, including:

- Drug or chemical reaction. Dental materials and medication may trigger allergic or sensitive reactions.
- Long term numbness (paresthesia). Local anesthetic, or its administration, while almost always adequate to allow comfort, can result in transient, or in rare instances, permanent numbness.
- Muscle or joint tenderness. Holding one's mouth open can result in muscle of jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
- Sensitivity in teeth or gums, infection, or bleeding.
- Swallowing or inhaling small objects.

While we follow procedural guidelines which most often lead to clinical success, just like any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I agree to the use of local anesthetic and the use of nitrous oxide depending on the judgment of Dr Slota. I understand that nitrous oxide may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure.

I understand and have been informed that there are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these being swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. In addition, the use of local anesthesia can result in long-term numbness that usually resolves itself. Needle breakage could also occur which would require surgical removal.

I also authorize Dr Slota to use photographs, radiographs, other diagnostic material and treatment records for the purpose of teaching, research and scientific publications.

The alternatives to these methods or treatments are:

a. Do not perform the recommended dental treatment
b. Alternative: _____

I have been advised and agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist must be maintained.

I hereby state that I have read and understand this consent, and each of the provisions contained herein has been explained to me by a dentist. Further, all questions about the procedures have been answered in a satisfactory manner and I understand that I have the right to be provided answers to questions which may arise during the course of my treatment.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patients Name_____**Date**_____

Signature_____

I certify that I have explained the above to the patient or legal guardian before requesting signature

Signature of Dentist_____

Notice of Privacy Practice (HIPPA)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review this information carefully. You have the right to receive a copy of this notice

At Denver Smiles, (aka Dr. Bernard Slota) we have always kept your information secure and confidential. A new law requires us to continue maintaining our 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 to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal health care operations. For example, one of our staff will enter your information in our computer.

We may share your medical information with our business associates such as billing service. We may 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 newsletters or other information by phone, email, voicemail, and text message. We also want to call, email, or text to remind you about your appointments and other patient care related information. If you are not home we may leave this information on your answering machine or with the person who answers the phone. If you wish to opt out to any of the methods of communication, please let a staff member know at your next appointment.

In an emergency, we may disclose your health information to a family member or another 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 describes above his practice will not use or disclose your health information without written authority.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail or email your files to you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding information you want to see. If you also want a copy of your records we may charge a reasonable fee for the copies. If we change any of the details of this notice we will notify you of the changes in writing.

You may file a complaint with the department of health and human services; 200 independence Ave. S.W. RM 509f, Washington DC 20201. You will not be retaliated against for filing a complaint. However before filing a complaint please contact our private office, Dr. Slota at 303-623-4444. This notice goes into effect as of April 14, 2003

SIGNATURE ACKNOWLEDGEMENT _____ **DATE** _____

Denver Smiles
Personalized & Comfortable

RECORDS RELEASE FORM

Patient: _____ Date of Birth: _____

Dentist Name: _____ Fax: _____

Release to: Bernard Slota
8015 West Alameda Avenue
Suite 115
Lakewood, CO 80226

Phone: 303-623-4444
Fax: 303-623-0443
Email: hello@denversmiles.com

Information Requested
__ Copy of complete dental chart
__ Copy of dental radiographs
__ Other (e.g. models-describe)

Purpose for which information is to be used
__ Transfer of records/ Changing Doctor
__ Second opinion
__ Specialist
__ Other: _____

Authorization:
I certify that this request has been made voluntary and that the information given above is accurate.

_____ _____
Signature Date

_____
Print Name

_____ _____
Person authorized to sign for the patient: (Print) Relationship