Welcome To Altitude Dental

Confidential Patient Information:
Name: _____Preferred Name: _____
Sex: M F Date of Birth: _____ SS# _____
Address: _____ City: _____St: _____ Zip: _____
Home Phone: _____Cell: _____
Email Address: _____

Emergency Contact: _____
How did you hear about our office?
Insurance Flyer Website Facebook Coupon Other: _____

Insurance Information
Insurance Name: _____ Insurance Phone:_____
Policyholder:_____ SS# _____ Birthday:_____
Policy Holders Employer: _____

Responsible Party (For Children Only)
Name: _____
Birth Date: _____SS# _____
Address: _____ City: _____ St:_____ Zip:_____
Home phone: _____ Cell: _____
Relationship To patient: _____

Dental Questionnaire:
Please circle any of the following that apply to you:

Bad Breath	Grinding	Jaw pain/popping	Tenders gums
Swollen Gums	Clenching	Packing food	Sensitivity
Tobacco Use			

What is you the reason for visit today? _____
When was your last dental cleaning? _____
Do you have any concerns? _____
_____
Are you happy with your smile? _____
If No, what would you like to change? _____

Are you interested in any of the following:

Invisalign	Whitening teeth	Preventative Care	Veneers
Implants	Crowns	Braces	

HEALTH QUESTIONAIRE

Please check each condition that applies to you. Check past or current conditions:

AIDS/HIV	Arthritis/Rheumatism	Asthma	Cancer
Heart problems	Abnormal Bleeding	Diabetes	Epilepsy
Glaucoma	Heart Murmur	High blood pressure	Stroke
Hepatitis: Type____	Kidney Disease	Psychiatric Care	Sinus Trouble
Anemia	Low Blood Pressure	Nervous Disorders	Ulcers
Tuberculosis	Back Problems	Blood Disorders	Chemotherapy
Artificial Joints	Cough Persistent	Respiratory Disease	Heart Problems
Fainting	Dizziness	Headaches	Liver Disease
Herpes	Jaw Pain	Radiation Treatment	Pacemaker
Swollen Feet	Rheumatic Fever	Mitral Value Prolapse	Tumor
High cholesterol	Shortness of breath	Auto Immune Disease	HPV

WOMEN ONLY: Are you pregnant or possibly pregnant? Y N Date Due:_____/_____/_____
Are you nursing? Y N

Are you Allergic to Latex? Y N

Do you have any food or drug allergies? (Medications, foods, dyes, ect.)
IF YES, Please List:

_____
_____
_____

List all Medications prescribed by your doctor, including birth control and hormone supplements:

_____
_____

List all non prescription OTC (over the counter) medications, vitamins, and herbal supplements you have taken in the last month.

_____
_____

Do you use any recreational drugs? (Heroin, Cocaine, ect.) Y N
If Yes, Please List: _____
Are you addicted or recovering from any drugs or alcohol? Y N

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test or if my medications change, I will inform the dentist at my next appointment.

_____ _____DATE ___/___/___
Signature of Patient, Parent or Guardian

FINANCIAL AND HIPPA POLCY:

Altitude Dental is pleased you have chosen us to be your dental provider. The office accepts many insurance plans to benefit our patients. As a condition of your treatment by Altitude Dental, financial arrangements must be made in advance. This practice depends upon the reimbursement from our patients for the costs incurred from their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

Patients who carry Dental insurance understand that all dental services rendered are charged directly to the patient and that he or she is personally responsible for payment of all service. Altitude Dental is happy to submit insurance forms for you to your designated insurance, and assist you with any outstanding claims that need to be resolved. However we are not the insurance company and cannot make the insurance company render payment for any services. We will credit any collections received to the patients account. Typically, most insurance plans will not pay in full for any services rendered, only a percentage. Therefore, this will leave a portion for the patient due at the time of service.
In consideration for the professional services rendered to me, or at my request for my minor child or ward, by the provider, I agree to pay the quoted price of services rendered to Altitude Dental at the time the services are rendered. I understand that I am financially responsible for all charges whether or not they are paid by a third party. (i.e. insurance company). For any payments that cannot be made at the time of service, I agree that any verbal agreement for payments is a legal agreement and I will be held to such agreements until the balance is paid in full.

A service charge of 1.75% per month (21% per annum) on the unpaid balance will be assessed on lal accounts exceeding 60 days from the date of service unless previously written arrangements have been satisfied. I understand that the fee estimate listed for dental services prescribed can only be extended for a period of 60 days. After that period, fees and treatment are subject to change at the discretion of the provider.
Altitude Dental offers many financing options. I understand that one of these options will need to be agreed upon prior to appointment date and time. Those financing options are:

1. Cash or Check
2. Credit Card (Visa, Master card, Discover, American Express).
3. Third Party Financing. (Care credit). (6 months or 12 months ONLY)

I agree to pay all attorney fees. court costs, filing costs, including commission or charges up to 40%, that may be assessed to me by Altitude Dental to pursue this matter with or without suit. I grant permission to Altitude Dental to contact me at home or place of business to discuss matters related to this form. I also agree to let this office leave messages concerning appointments on my answering phone or with a family member.

I authorize release of all identifiable information concerning my account, including charges billed, payments made, and interest charges etc to Altitude Dental and any collection agency they decide to use. I authorize release of information to insurance carriers to collect on my behalf. I authorize payment directly to Altitude Dental.

I understand that there will be a 50$ charge on all returned checks. I understand that after one check is returned, the only method of payment to this office will cash or credit card. **I understand that a 48 hours notice is required to cancel or change any scheduled appointments, and a 50$ cancellation fee applies to failed or broken appointments.**

This agreement supersedes all prior agreements signed, including any and all mediation or arbitration agreements. I acknowledge that any prior mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void. I acknowledge that I have received a copy of Altitude Dentals Privacy Policy (HIPPA Agreement). I hereby agree to abide by the conditions outlined herein.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

1. Conduct plan and direct my treatment and follow up among multiple healthcare providers, involved directly or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of the Office Privacy Policies containing a more complete description of the uses and disclosures of my health information. I have been given the right t review such Office Privacy Policies prior to signing this consent. I understand that this business has the right to change its Office Privacy Policies from time to time and that I may contact the business at any time to obtain a copy.
I understand that I may request in writing that you restrict how my private information is being used or disclosed to carry out treatment, payment, and healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Altitude Dental has taken action on this consent.

_____ _____/_____/_____

Signature of Patient, Parent or Guardian Date

CONSENT TO PROCEED:

I authorize Altitude Dental and/or such associates or assistants that Altitude Dental may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health ot the dental health of any minor or other individual for which I have responsibility, including arrangements, the administration of any sedatives (including nitrous oxide), analgesic, therapeutic, and /or other pharmaceutical agent (s), including those related to restorative, palliative ,therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an outward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, muscle soreness and temporarily or rarely permanent numbness. I understand that occasionally needles may break and may require surgical removal.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, the teeth may remain sensitive or even possibly painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during or after treatment. Although rare, it is possible for the tongue, cheek or other oral tissues to be advertently abraded or lacerated during routine dental procedures. In some cases, sutures or additional treatment is required.

I understand that as a part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc may be aspirated or swallowed. This very unusual situation may require a series of x rays to be taken by a physician or hospital and may, in rare cases require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been in the past, Such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva, Actonel may result in complications of non healing of the jawbone following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved ,for my benefit or the benefit of my minor or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been goven the opportunity to ask questions.

I also acknowledge that all of the preceding answers and information provided on all forms filled out are true and correct. If I ever have any changes in my health or there are changes to my child's health I will inform Altitude Dental at the next appointment without fail. If changes are not reported, I agree that any damages incurred will be solely my responsibility, financially and legally. I acknowledge that I have the right to refuse treatment at which time I must sign the proper refusal forms. I agree that I will be responsible for any damage incurred if the prescribed treatment is not rendered within a reasonable amount of time.

_____ _____/_____/_____

Signature of Patient, Parent or Guardian Date

OPTIONAL

CONSENT FOR PHOTO/IMAGE USE

I, the undersigned, hereby authorize the office of Altitude Dental to use images of me and my minor child to be placed in a book of case examples, for website postings or for marketing purposes.
By signing this authorization I waive any claims of breach of privacy pertaining to the release of any photographic or digital image. I acknowledge that I have received a copy of the privacy policies of this office.

_____ _____/_____/_____

Signature of Patient, Parent or Guardian Date

_____ _____/_____/_____

Witness Signature (Staff Member). Date