PALMER PARK
FAMILY & COSMETIC
DENTISTRY

PATIENT REGISTRATION INTAKE FORM

(719) 301-5300
3208 N Academy Blvd Ste #140
Colorado Springs, 80917

Today's Date:	New Patient: ☐	**Responsible Party:** Name: _____ Relationship to Patient: _____

PATIENT INFORMATION

Patient Name: _____ MI _____ _____	Birth date: _____/_____/_____ Age: _____ Sex: ☐ F ☐ M	**Marital Status:** ☐ Married ☐ Single ☐ Separated ☐ Minor ☐ Divorced ☐ Partnered for _____ Years

Social Security: _____-_____-_____	Home Phone: (_____)_____	Cell Phone: (_____)_____

Home Address: _____	City / State _____	Zip Code: _____

Email Address: _____ Opt out of Mailings: ☐

Who can we thank for this referral? _____

How did you find us?: ☐ Website ☐ Internet Search ☐ Newspaper ☐ Bench Advertisement ☐ Television ☐ Family /Friend ☐ Walk-In

INSURANCE INFORMATION

Spouse's Name	Spouse's Employer	Spouse's SS#	
Occupation:	Employer/School:	Employer/School address:	Employer/School phone no.:

PRIMARY Insurance Provider:

Subscriber's name:	Subscriber's SS#:	Birth date:	ID #:	Group #:	Co-payment: $

SECONDARY Insurance Provider:

Subscriber's name:	Subscriber's SS#:	Birth date:	ID#:	Group #:	Co-payment: $

IN CASE OF EMERGENCY

Name of local relative or friend (not living at same address):	Relationship to patient:	Home Phone:	Work Phone:

_____ _____

Patient/Guardian signature Date

We are dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare

We use and disclose the information we collect from you only as allowed by the Heath Insurance Portability and Accountability Act. This includes issues relating to your treatment, payment, and our dental care operations. You may give written authorization for us to disclose your information to anyone you choose, for any purpose but it will never otherwise be given to anyone-even family members-without your written consent.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy and practices apply to all current and former patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations and comply with the law. This may include your name, address, telephone number(s), Social Security number, employment date, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, the information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. This includes issues in which we reasonably believe you may be a victim of abuse, neglect, domestic or other crimes. We are also obligated to provide information to law enforcement officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patent Rights

You have a right to get copies of your healthcare information; to obtain copies in a variety of formats; and to a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can, also, notify the U.S. Department of Human Services.

We thank you for being a patient at our practice. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

PATIENT REGISTRATION INTAKE FORM

Today's Date:	

HEALTH HISTORY

Patient's Last Name:	First:	Middle:	

Please check to indicate if you have had any of the following:

☐ AIDS/HIV	☐ Epilepsy	☐ Respiratory Disease
☐ Anemia	☐ Fainting or dizziness	☐ Rheumatic Fever
☐ Arthritis, Rheumatism	☐ Glaucoma	☐ Scarlet Fever
☐ Artificial Heart Valves	☐ Headaches	☐ Shortness of Breath
☐ Artificial Joints	☐ Heart Murmur	☐ Sinus Trouble
☐ Asthma	☐ Heart Problems	☐ Skin Rash
☐ Back Problems	☐ Hepatitis Type _____	☐ Special Diet
☐ Bleeding abnormally, with extractions or surgery	☐ Herpes	☐ Stroke
	☐ High Blood Pressure	☐ Swollen Feet of Ankles
☐ Blood Disease	☐ Jaundice	☐ Swollen Neck Glands
☐ Cancer	☐ Jaw Pain	☐ Thyroid Problems
☐ Chemical Dependency	☐ Kidney Disease	☐ Tonsillitis
☐ Chemotherapy	☐ Liver Disease	☐ Tuberculosis
☐ Circulatory Problems	☐ Low Blood Pressure	☐ Tumor or growth on head or neck
☐ Congenital Heart Lesions	☐ Mitral Valve Prolapse	☐ Ulcer
☐ Cortisone Treatments	☐ Nervous Problems	☐ Venereal Disease
☐ Cough, persistent or bloody	☐ Pacemaker	☐ Weight loss, unexplained
☐ Diabetes	☐ Psychiatric Care	
☐ Emphysema	☐ Radiation Treatment	

Do you wear contact lenses?	Do you smoke?	
◯ Yes ◯ No	◯ Yes ◯ No	

WOMEN

Are you pregnant?	Taking birth control pills?	Are you Nursing?
◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Due Date: _____		

Reason for Visit: _____

_____

Pharmacy Name:	Pharmacy Phone Number:	Primary Physician / Phone:
_____	_____	_____/_____

MEDICATIONS

Please list any medications you are currently taking and the correlating diagnosis:

_____

_____

Allergies

☐ Aspirin	☐ Metals
☐ Codeine	☐ Penicillin
☐ Dental Anesthetics	☐ Tetracycline
☐ Jewelry	☐ _____
☐ Latex	☐ _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____

Please check appropriate boxes to indicate where we may leave messages if we do not talk to you personally.

WORK:

- ☐ Leave message on work phone
- ☐ Leave message on work mobile phone
- ☐ Leave message with work supervisor

HOME:

- ☐ Leave message on home voicemail
- ☐ Leave message on mobile phone
- ☐ Leave message with family member

Family Members:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

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
- ☐ Communications barriers obtaining the acknowledgement
- ☐ Other Photographs
- ☐ Self
- ☐ Family

FINANCIAL POLICY:

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. Any difference in payment from your insurance company and your account balance is your responsibility.

Insurance assignment: Insurance benefits are estimates only. I understand I am responsible for any co-payments and deductibles, as well as any procedures not covered by my insurance company. I authorize payment directly to Prestige Dental Center/Prestige Denture Clinic. I understand I am responsible for all costs of treatment. I grant the right for Prestige Dental Centers/Prestige Denture Clinic to release my dental/medical histories and other information about my dental treatment to third party payers and/or health practitioners. If a bill is unpaid 90 days or more, a collection agency will be used, and I will be responsible for all collection costs and legal fees accumulated on my behalf or that of my dependents.

Appointment cancellations with less than 48 hours' notice or failed appointments will have a $50 charge for an appointment with a hygienist and a minimum of $50 with a maximum of $300 for an appointment with a dentist, depending on the length of the appointment. (Cancelations due to weather will not be charged)

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am aware past due accounts will be subject to a charge of 1.5% per month interest. I am responsible for all collection costs insured by the dental office and on a returned check, a fee of $30.00.

PLEASE NOTE Divorced Parents: The parent who is present with the patient at time of appointment will be considered the "financially responsible party" and will be accountable for all fees incurred.

_____ _____

Signature of Patient or Responsible Party Date

Cancelling/Rescheduling Appointments:

Palmer Park Dentistry has instituted a new policy regarding cancellations and reschedules. If we are not given 24-hour notice of a cancellations or reschedules, it will count as a strike in our 3-strike policy. After the third strike a patient will be dismissed from the office, and their records will be sent to the office of their choice.

MEDICAID PATIENTS: I understand I must submit my current Medicaid identification card along with a valid picture ID on the day service is rendered.

I am aware that I am financially responsible for services not covered by the Colorado Medicaid Dental Program.

Colorado Medicaid Dental Program has a maximum of $1500 for adults 21 years of age and older. I am aware that I am financially responsible for any services that exceed the $1500 maximum.

I also understand after Medicaid has processed the claim there may be a portion of the balance which will be my responsibility. I agree to pay this balance within 30 days.

_____ _____

Member Signature Date

_____ _____

Parent or Guardian Signature Date

(*required if member is under the age of 18)