COTTONWOOD CREEK DENTAL

Welcome

THANK YOU FOR SELECTING OUR DENTAL HEALTHCARE TEAM. PLEASE FILL OUT THIS FORM COMPLETELY. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE, JUST ASK US AND WE WiII BE HAPPY TO HELP.

PATIENT INFORMATION (CONFIDENTIAL)

NAME_____ BIRTH DATE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

SOC. SEC. #_____ HOME#_____

WORK#_____ CELL#_____

EMPLOYER_____ SPOUSE OR PARENT'S NAME _____

YOUR EMAIL ADDRESS:_____

IN CASE OF EMERGENCY WHOM MAY WE CONTACT? _____ PHONE#_____

WHOM MAY WE THANK FOR REFERRING YOU? _____ PHONE#_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE
FOR THIS ACCOUNT
IF OTHER THAN SELF _____ RELATIONSHIP_____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? _____ YES _____ NO

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME#_____WORK#_____ CELL#_____

FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT. PLEASE CHECK THE OPTION YOU PREFER. PAYMENT/CO PAYS ARE DUE AT THE TIME OF SERVICE.

_____CASH _____ PERSONAL CHECK _____ CREDIT CARD _____ I WISH TO DISCUSS A PAYMENT PLAN

PRIMARY INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT_____

HEALTH ID PLAN#_____ BIRTH DATE_____ INS. COMP. PHONE#_____

NAME OF EMPLOYER_____DATE EMPLOYED_____

INSURANCE COMPANY _____ POLICY/GROUP ID#_____

SECONDARY INSURANCE INFORMATION

DO YOU HAVE ANY SECONDARY INSURANCE? _____ YES _____ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT_____

HEALTH ID PLAN#_____ BIRTH DATE_____ INS. COMP. PHONE#_____

NAME OF EMPLOYER_____DATE EMPLOYED_____

INSURANCE COMPANY _____ POLICY/GROUP ID#_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Financial Policy

1. **If you have insurance we will gladly process your claim, but we ask that you pay your estimated portion when services are rendered. However, if your insurance company has not paid your claim within 90 days, the sum of the balance becomes your responsibility.**

2. **You are responsible for all fees regardless of insurance coverage: it is your responsibility to know your insurance coverage and all exclusions, maximums and waiting periods.**

3. **Payment options are as follows:**
    1. **Visa, Master and Discover cards**
    2. **Personal check, a $30 fee will be charged on all returned NSF checks**
    3. **Line of credit with Care Credit (ask us for information)**
    4. **If in the event that your payments are not received within 30 days of their due date your account will be charged a monthly 1.5 percent or minimum $1.50 finance charge per month. If your account becomes seriously delinquent, we will turn it over to a collection agency. You will be responsible for all costs associated with the collections, including but not limited to attorney's fees.**
    5. **Fees are subject to change. Treatment plans will be honored for 1 calendar year.**

Scheduling Policy

If you are more than 15 minutes late for your appointment it is possible that you will have to be rescheduled.

1. We ask that you kindly give at least a *24 hour notice to reschedule or cancel an appointment.*

2. "*No Show*" *appointments cost time and money for everyone*. If you don't show for an appointment and we were not notified 24 hours before, you may be *charged* for that appointment. It will also be at the discretion of the office to ask you to seek another dental provider if you continue to "no show" for appointments.

SIGNATURE_____ DATE_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY**

The Health Insurance Portability & Accountability Act of 1996("HIPAA") is a federal program that requires that all medical records and other individually deniable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes; treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you believe that your privacy protections have been violated. You have the right to file a written complaint to our office, or with the Department of Health and Human Services, office of Civil Rights about violations of the provisions in this notice or the policy and procedures of our office. We will not retaliate against you for filling a complaint.

Patient Name_____ Date_____

Signature_____

Cottonwood Creek Dental
610 Boardwalk Avenue, Suite 201
Bozeman, MT 59718

General Dental Treatment Consent Form

Please read and initial all sections below and sign at the bottom of the form. Thank you!

Patient Name: _____

Drugs, Medications & Local Anesthetics **Initials:** _____

I understand that antibiotics, analgesics and other medications can cause allergic reactions that result in redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I also understand there are risks of local anesthesia that may affect my body such as dizziness, nausea, vomiting, accelerated/slow heart rate, or various types of allergic reactions. It may also cause injury to nerves that can result in pain, tingling, or numbness that may persist for several weeks, months, or rarely, be permanent. I have informed my dentist of my complete medical history, including any recent surgeries, changes in my medical history, & any known allergies.

Changes in Treatment Plan **Initials:** _____

I understand that during treatment, it may be necessary to change , add or subtract procedures because of conditions found while working on the teeth that were not discovered during initial examination. Upon my consent, I will give my permission to consider all changes and additions as necessary.

Fillings **Initials:** _____

I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy.

Crowns (Caps) and Bridges **Initials:** _____

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown or bridge (including shape, fit size, and color) will be before cementation.

Endodontic Treatment (Root Canal Therapy) **Initials:** _____

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment. I understand that root canals can fail and may require additional treatment or I may end up having the tooth extracted. I also understand that occasionally additional surgical procedures may be necessary following root canal treatment, such as re-treatments or apicoectomy.

Alternative Treatment **Initials:** _____

I understand that I have the right to choose, on the basis of adequate information, from alternate treatment plans that meet professional standards of care. The treatment plan chosen by me may/may not be the procedure that Dr. Stutts and/or Dr. Raaf prefers.

By signing below, I consent to the general dental treatments and/or proposed treatment agreed by Dr. Stutts and/or Dr. Raaf and myself.

Patient/Guardian Signature: _____ **Date:** _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

THIS NOTICE ALLOWS THE PATIENT TO DESIGNATE A PERSON WHO IS AUTHORIZED TO RECEVIE COMMUNICATION REGARDING YOUR DENTAL TREATMENT AND OR ACCOUNT INFORMATION.

Today's Date:_____

Patient Name_____ DOB:_____

I authorize Cottonwood Creek Dental to release my complete dental health record to include all past, present, and future treatment, and all information related to my account for billing and collections to the following person/people:

_____ _____
Name of Person Authorized Relation

_____ _____
Name of Person Authorized Relation

_____ _____
Name of Person Authorized Relation

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of Patient or Guardian

_____
Printed Name of Patient or Guardian and Relationship to Patient

_____
Date