FORT COLLINS DENTAL ARTS

GUY LEAVITT, DDS

PATIENT INFORMATION

Name_____ Birth date_____ Social Security #_____-_____-_____

Address_____City_____ State_____

Zip_____Phone_____**Cell Phone**_____

Email Address_____ Single Married Widowed Separated Divorced

Employer_____ Work Phone_____

Emergency Contact and Phone Number _____

Whom may we thank for referring you? _____

Health and Dental History

Physician's name_____ Phone_____

Date of last visit_____ Have you had any serious illnesses or operations? Yes No

If yes, please describe_____

Are you currently under physician care? **Yes No** If yes, please describe_____

Women: Are you pregnant? **Yes No** Nursing? **Yes No** Taking Birth control pills? **Yes No**

Are you currently taking any medications, including OTC and/or herbal supplements? Yes No If yes, please list

_____

_____

Have you ever taken or are you taking Fosamax or Bisphosphates? Circle One: **YES** **NO**

HEALTH CONCERNS: Please check if you have had any of the following:

☐Anemia	☐Heart Disease/Problems	☐Respiratory Problems
☐Arthritis	☐Heart Murmur	☐Rheumatic Fever
☐Artificial Joints	☐Hepatitis	☐Rheumatism
☐Asthma	☐High Blood Pressure	☐Sinus Problems
☐Blood Disease	☐HIV/AIDS	☐Stomach Problems
☐Cancer	☐Jaundice	☐Stroke
☐Diabetes	☐Kidney Disease	☐Tuberculosis
☐Dizziness/Fainting	☐Liver Disease	☐Tumors
☐Epilepsy	☐Nervous Disorder	☐Ulcers
☐Excessive Bleeding	☐Pacemaker	☐Glaucoma
☐Pregnancy	☐Head Injuries	☐Radiation Treatment ☐See Pt. Notes

☐Other_____

DENTAL CONCERNS: Please check if you have any of the following:

☐Bells Palsy	☐Grinding	☐Loose Teeth
☐Clenching	☐Gums Bleed	☐Lip Biter
☐Congested Ears	☐Headaches	☐Ringing Ears
☐Difficulty Chewing	☐Halitosis (bad breath)	☐Sensitive teeth- hot or cold
☐Difficulty Swallowing	☐Insomnia/frequent waking	☐Sores or Lumps in mouth
☐Facial Pain	☐Jaw Pain	☐Tobacco Use
☐Floss shreds when using	☐Jaw Popping	☐Tingling in fingers
☐Food catches between teeth	☐Limited Opening	☐Other_____

ALLERGIES TO MEDICATIONS OR LATEX_____

How would you rate your dental anxiety on the scale below:

Not anxious **Very anxious**

1 2 3 4 5 6 7 8 9 10

_____

I authorize Dr. Guy Leavitt to administer medications and perform diagnostic photographic procedures as necessary for proper dental care. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and other health professionals.

Signature_____Date_____

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INSURANCE INFORMATION

Name of Policy Holder_____ Policy Holder Date of Birth_____
Policy Holder Social Security #or Member I.D. #_____
Relationship to Patient (If not self):_____

Insurance Company: _____Group #: _____
Insurance Phone Number:_____

Insurance and Payment Policies

FEE FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT FOR PATIENTS WITHOUT DENTAL INSURANCE

- We are committed to provide you with the best possible care. If you have dental insurance, we are more than happy to help you receive your maximum allowable benefits. To achieve this goal, we need your assistance, and your understanding of our payment policy. We will be happy to process your insurance claims for your reimbursement.
- We will answer any questions relating to your insurance but you must realize, however, that:
    - Your insurance is a contract between you, your employer, and the insurance company.
    - Most insurance companies have a deductible that must be met before the company will pay their portion. If you have not met your deductible for the year, you are responsible for any charges until the deductible is met. Even after the deductible is met, insurance companies only pay a percentage up to the yearly allowance and you will be responsible for the remainder.
    - Not all services are a covered benefit in all contracts. Some insurances arbitrarily select certain services they will not cover.
    - Any claims unpaid after 90 days will automatically become patient responsibility.

Collections: In the event Fort Collins Dental Arts, in its sole discretion, commences collection action against PATIENT for nonpayment or partial payments of services, ALL attorney fees, collection fees, filing fees, and all associated fees with the pursuit of collections will be patient responsibility.

ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are provided. We accept cash, check, Visa, Mastercard, American Express and Care Credit. We will be happy to help you process your insurance claim for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit.

Office Policy and Consent Form

- Your appointment time is set-aside especially for you. We ask for courtesy to Dr. Leavitt and to other patients that you keep your scheduled appointments. If you must change or miss an appointment we would appreciate a 48 hr. notice. Less than a 24hr cancellation or failure to arrive at your scheduled appointment could result in a broken appointment charge of $25.00 or no re-appointment.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
- We will be fair in working out finances with you, but please also be fair to us with your commitments. A 1.5% finance change will be assessed monthly on all overdue balances.
- Please note for your convenience we do accept VISA, American Express, MasterCard, and Discover, CareCredit as well as checks and cash.

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WE MUST EMPHASIZE THAT AS A DENTAL CARE PROVIDER, OUR RELATIONSHIP IS WITH YOU NOT YOUR INSURANCE COMPANY. WHILE FILING OF YOUR INSURANCE CLAIMS IS A *COURTESY* THAT WE EXTEND TO OUR PATIENTS, ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE OF SERVICE PROVIDED

CONSENT: I understand that responsibility for payment of services provided in this office for myself and any dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all cost of collections including attorney fees, collection fees in the amount of 25% of the principal balance due, and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% per annum (1.5% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand I am responsible for payment of fees not covered by insurance.** I also assign all benefits to Guy Leavitt, D.D.S. I acknowledge that my signature on this document authorizes the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996.

Responsible Party's Signature: _____ Date: _____

Fort Collins Dental Arts 3950 John F Kennedy Pkwy Suite E Fort Collins, CO 80525

I to communicate via phone numbers, e-mail addresses, and via text message with ***Fort Collins Dental Arts*** on matters related to my health and/or my medical treatment. I understand that any Confidential Personal Health Information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, nor any of its workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail. I also understand that it is not the policy of the practice to encrypt any Confidential Personal Health Information that I request to be sent to me via e-mail. Because this information is not encrypted I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

ACKNOWLEDGEMENT FOR NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish. I grant Fort Collins Dental Arts to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. You have the right to revoke your consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this consent we may decline to treat you. You are entitled to a copy of this form after you sign it. I have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities, and health care operations.

Patient Name/Guardian: _____Date:_____

OPTIONAL: Medical Information Sharing and Disclosure

I authorize Fort Collins Dental Arts to share or disclose any and all of my medical information with those individuals listed below (checked boxes only):

- ❑ Spouse: Full Name _____
- ❑ Parent (s): Full Name (s): _____
- ❑ Other: Full Name (s): _____

Name of Privacy Officer: **Dr. Guy Leavitt** Practice Address: **3950 John F Kennedy Pkwy, Suite E, Fort Collins, CO 80525**

Phone:**970-267-0993** Fax:**970-267-0997** Email: office@fcdentalarts.com FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.Due to an emergency situation it was not possible to obtain an acknowledgement.Other *(Please provide specific details):*
-

Employee signature _____ _____ Date _____