Patient Information

Patient's Name____ Birth Date____/____/____

Spouse's Name____ Birth Date____/____/____

Patient's SS #______________________________ Spouse's SS #______________________________

If Child, Parent's Name____

Mailing Address____ Cell Phone______________

Street Address____ Home Phone______________

Email______________________________ Would you like to be contacted by Text?______________

Patient Employed by (parent if minor)_________________________________ Phone______________

Business Address____

Present Position____

Spouse's Employer____

In case of Emergency, who should be notified?__________________________ Phone______________

Person responsible for this account____

Whom May we thank for referring you?____

Authorization: I understand that I am responsible for all costs of dental treatment and that payment is expected at the time services are rendered. I hereby authorize Gerlinde Ehni, D.D.S., P.C. to administer such medications and perform such diagnostic and therapeutic procedures as discussed that may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

Signature of responsible party____ Date____/____/____

Let us know something about your goals........

Where do you want to be in the future with your smile, chewing ability and comfort?

____

____

If you had a magic wand, what would you change about the appearance of your teeth and smile?

Whiter __________ **Straighter** __________ **Longer** __________ **Shorter** __________

Less Crowded __________ **Close the gaps** __________ **Less "gummy" smile** __________

What can we do to make your visit more pleasant?

____

____

PATIENT NAME ______ **Date** ______

Primary reason for appointment [ ] Examination [ ] Emergency [ ] Consultation

Medical History

Your physician ______ Phone ______

What medications, drugs or pills are you taking? ______ Ever taken Fen-phen___ Yes No

Are you taking homeopathic remedies or herbs? List ______ Yes No

Have you had a major operation or been hospitalized? ______ Yes No

Have you ever had a serious injury to your neck or head? ______ Yes No

Are you on a special diet? Discuss ______ Yes No

Are you allergic or sensitive to any medications/substances ______ Yes No

[ ] ASPIRIN [ ] CODEINE [ ] PENICILLIN [ ] LATEX [ ] ACRYLIC [ ] METAL

[ ] OTHER ______

Do you have or have you had any of the following? Please check the appropriate boxes.

	Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	[ ]	[ ]	**Night Sweats**	[ ]	[ ]	**Hypoglycemia**	[ ]	[ ]
Heart Murmer	[ ]	[ ]	**Bruise Easily**	[ ]	[ ]	**Liver Disease**	[ ]	[ ]
Irregular Heartbeat	[ ]	[ ]	**Yellow Jaundice**	[ ]	[ ]	**Hepatitis A**	[ ]	[ ]
Angina/chest pain	[ ]	[ ]	**Sickle Cell Disease**	[ ]	[ ]	**Hepatitis B or C**	[ ]	[ ]
Heart Attack/Failure	[ ]	[ ]	**Hemophilia**	[ ]	[ ]	**Kidney Problems**	[ ]	[ ]
Congenital Heart Disorder	[ ]	[ ]	**Leukemia**	[ ]	[ ]	**Renal Disease**	[ ]	[ ]
Mitral Valve Prolapse	[ ]	[ ]	**Emphysema**	[ ]	[ ]	**Thyroid Disease**	[ ]	[ ]
Scarlet Fever	[ ]	[ ]	**Tuberculosis**	[ ]	[ ]	**Parathyroid Disease**	[ ]	[ ]
Rheumatic Fever	[ ]	[ ]	**Lung Disease**	[ ]	[ ]	**Arthritis/Gout**	[ ]	[ ]
Pacemaker	[ ]	[ ]	**Breathing Problem**	[ ]	[ ]	**Rheumatism**	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	**Shortness of Breath**	[ ]	[ ]	**Pain in Jaw Joints**	[ ]	[ ]
Low Blood Pressure	[ ]	[ ]	**Frequent Cough**	[ ]	[ ]	**Cortisone Medicine**	[ ]	[ ]
Blood Disease	[ ]	[ ]	**Hay Fever**	[ ]	[ ]	**Artificial Joint**	[ ]	[ ]
Unexplained Fever	[ ]	[ ]	**Sinus Trouble**	[ ]	[ ]	**Venereal Disease**	[ ]	[ ]
Heart Surgery	[ ]	[ ]	**Asthma**	[ ]	[ ]	**Recent Weight Loss**	[ ]	[ ]
Artificial Heart Valve	[ ]	[ ]	**Bloody Sputum**	[ ]	[ ]	**AIDS**	[ ]	[ ]
Swelling of Limbs	[ ]	[ ]	**Ulcers**	[ ]	[ ]	**HIV Positive**	[ ]	[ ]
Recent Blood Transfusion	[ ]	[ ]	**Frequent Diarrhea**	[ ]	[ ]	**Genital Herpes**	[ ]	[ ]
Anemia	[ ]	[ ]	**Stomach/Intestinal Disease**	[ ]	[ ]	**Drug Addiction**	[ ]	[ ]
Excessive Bleeding	[ ]	[ ]	**Diabetes**	[ ]	[ ]			

	Yes	No		Yes	No		Yes	No
Excessive Thirst	☐	☐	**Fainting or Dizziness**	☐	☐	**Allergies (Pollen,Dust)**	☐	☐
Cold Sores	☐	☐	**Glaucoma**	☐	☐	**Hives or Rash**	☐	☐
Fever Blisters	☐	☐	**Tumors or Growths**	☐	☐	**Chemotherapy**	☐	☐
Herpes	☐	☐	**Nervousness**	☐	☐	**Radiation(X-Ray)Treatmnt**	☐	☐
Stroke	☐	☐	**Psychiatric Care**	☐	☐	**Cancer**	☐	☐
Convulsions	☐	☐	**Alzheimer's Disease**	☐	☐			
Epilepsy or Seizures	☐	☐	**Allergies (medicines)**	☐	☐			

Women (please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking Oral contraceptives. Discuss ________________ Yes No

1. Are you being treated for cancer of any kind? Yes____ No____
2. Have you or are you receiving any drugs in your veins, such as:
   a. Aredia Yes____ No____
   b. Zometa Yes____ No____
3. Are you being treated for loss of bone density? Yes____ No____
4. Are you taking any medications to treat bone density? Yes____ No____
   If so, please list the name: ________________.
5. Who is your physician who monitors these bisphosphonate drugs for you?

   Name____________________________ Telephone No.________________

   Name____________________________ Telephone No.________________

6. May I have your permission to speak directly with you physician(s) regarding your treatment? Yes____ No____

Have you ever had any other serious illnesses not checked above? Discuss. ____ Yes No

Do you wish to talk to the dentist privately about any problem?____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status, or if my Medicines change, I shall inform the dentist and staff at the next appointment.

X____ Date________________

Patient Signature; Parent or Guardian

Reviewed By Doctor____ Date________________

GERLINDE EHNI, D.D.S., P.C.

Office Business Practices

- I understand that I am responsible for all costs of dental treatment and that payment is expected at the time services are rendered.
- If I have dental insurance, I will discuss this with the business assistant in advance. (For your convenience, we will file insurance claims on your behalf to your insurance company.)
- Payment may be made by cash, check, VISA, MasterCard or American Express.

For patients paying out of pocket and without dental insurance:
We offer a 5% bookkeeping courtesy for cash or check payments the day of treatment.
We offer a 10% bookkeeping courtesy for cash or check payments for accepted treatment plans over $1,500.00 if made one (1) week in advance of treatment initiation.
For extensive treatment plans, flexible payment plan options available for qualifying individuals. Please ask the Business Assistant for further details

I understand that my insurance is an agreement between me and my insurance company. I also understand that I am responsible for my balance at the time services are rendered, regardless of my insurance. This office chooses to allow payment of the estimated patient portion only and accepts the balance of the payment directly from the insurance company (provided the insurance company will send the check directly to us). In the event that the insurance company does not pay the estimated amount to this office, the balance will be due from the patient within thirty (30) days.

A billing charge of $10 will be added to any balance that is over 30 days (60 days for insurance accounts). This charge will be added to the account each billing period until the account is paid. If a check is returned to Dr. Ehni-Snyder for insufficient funds, closed account, etc., a $25 fee, in addition to any bank charges will be assessed to the account.

A fee of $100 may be charged for patients who miss or cancel more than 2 times in a calendar year without giving at least 48 business hour notice.

I have read and understand the above practices.

Signature of patient (or parent of child) ______________________________

Permission for Electronic Transmission of Data

I______________________________, hereby give my permission to Dr. Ehni-Snyder and Staff to electronically transfer information concerning me to other providers for the purpose of a specialty referral and my insurance company (if applicable). *I understand that the electronic transfer may or may not be done on a secure email or fax.*

____
(Sign name)

Patients with dental insurance, please complete the section below

Name of Insured______________________________ Date of Birth ______________

Name of Insurance Company______________________________Subscriber ID______________Group ID__________

Authorization for Release of Information: I authorize the facility to release information from the patient's dental records which may be necessary to any insurance company, entity, or agency to make a determination of its obligation to make reimbursement for any or all of the patient's charges. I hereby release the facility and the patient's attending dentist from any liability for the furnishing of information from or copies of the patient's medical records for purposes of reimbursement. I acknowledge that upon the disclosure of dental record information to an insurance company or other payer pursuant to this authorization, the facility is no longer responsible for the confidentiality of any information known or possessed by the payer.

Terms:
Patients are expected to pay both the deductible and their percentage of treatment at the time services are rendered. We will assist in estimating the patient portion of costs. This is only an estimate and the responsible party is ultimately liable for any charges that insurance does not cover. Any insurance that is outstanding after 90 days will become the responsibility of the insured. In the event that the account is placed for collection, the guarantor will be responsible for all collection and attorney fees.

I hereby assign dental benefit payments from my insurance company directly to Dr. Gerlinde Ehni-Snyder, not to exceed the amount of the regular charges, from any insurance or health care benefits, otherwise payable to me or the patient for dental services provided.

Signature of responsible party (or parent of child) ______________________________ Date: ______________

Revocation of Authorization: I hereby revoke my authorization to release information.

Signature of responsible party (or parent of child) ______________________________

Date: ______________

Dental Arts A Work of Hearts
General Dentist

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Fax: (970) 264-2299
ehnidds@gmail.com

CONSENT TO SHARE CONFIDENTIAL MEDICAL/DENTAL INFORMATION

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: ______________________________
Date of Birth: ______________________________
EMERGENCY CONTACT: ____________________ **PHONE:** ______________

I HEREBY AUTHORIZE Dental Arts a Work Of Hearts TO SHARE:

( ) All of my medical/dental information
( ) My X-rays
( ) My appointment times, dates, location, And reasons for the visits
( ) The medications I am taking
( ) The following information (specify) ______________

WITH THE FOLLOWING PEOPLE:

Full Name ______________________ Relationship ______________
Full Name ______________________ Relationship ______________
Full Name ______________________ Relationship ______________
Full Name ______________________ Relationship ______________

I understand that I may cancel the consent at any time **(by writing to Dental Arts, A Work of Hearts)** but that cancelling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my dental provider or my clinic to share my information with someone.

Signature: ______________________ **Date** ______________
Relationship to minor patient (if parent or legal guardian)
______________________If you are not the minor patient's parent, you must give us proof of guardianship (for example a court order or power of attorney).
Witness ______________________ **Date** ______________

A minor patient's signature is required for us to share information about care for **(1)** conditions relating to the minor's sexuality including, but not limited to: family planning and sexually transmitted diseases **(age 14 and above)**. **(2) alcoholism and/or drug abuse (age 13 and above)**, and **(3) mental health conditions (age 13 and above).**

GERLINDE EHNI, D.D.S., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

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

____

Please Print Name

____

Signature

____

Date

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

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (Please Specify)

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