www.huserdentistry.com
7555 E Hampden Ave #425 Denver, CO 80231
(303) 773-1211

**Patient Information:**

Patient Name: _____________________________________________ Preferred Name: _______________________
Date of Birth: _________________ Male: _____ Female: _____ Married: _____ Single: _____ Minor: Y N
SS #: _____________________________________
Address: _____________________________________ City: _________________________ State: ____ Zip: _____
Home phone #: _______________________ Work #: _______________________ Cell #: ______________________
E-mail address: _______________________________________________ Best way to reach you: _______________
Employer: ____________________________________________________ Occupation: _________________________
Emergency Contact: ___________________________________________ Phone #: ___________________________
How were you referred to us: _________________________________________________________________________

**Parent/Guardian Information (if patient is a minor):**

Name: _____________________________________________________ Relationship to patient: ________________
Date of Birth: ____________________ SS #: _____________________ Driver's License #: ____________________
Address: ____________________________________ City: _________________________ State: ___ Zip: ______
Home Phone #: ____________________ Work #: ___________________________ Cell #: ____________________

**Dental Insurance Information (Primary):**

Policyholder's Name: ___________________________________ Date of Birth: ___________ SS #: _____________
Insurance Company: ________________________________________________________ Group #: ______________
Employer: ____________________________________________ Policyholder's ID #: __________________________
Patient's relationship to policyholder: Self: _____ Spouse: _____ Child: _____ Student: _____ Other: _____

**Dental Insurance Information (Secondary):**

Policyholder's Name: ___________________________________ Date of Birth: ___________ SS #: _____________
Insurance Company: ________________________________________________________ Group #: ______________
Employer: ____________________________________________ Policyholder's ID #: __________________________
Patient's relationship to policyholder: Self: _____ Spouse: _____ Child: _____ Student: _____ Other: ____

**Consent for Services:**

I understand that I am financially responsible for all charges, whether or not paid by my insurance, for all services rendered on my behalf or my dependents. Treatment recommendations are based on what is best for me; not recommended based on what will or not will be covered by my insurance plan. I authorize the doctor and/or provider of services to release any information required to secure payment of benefits. I understand that I may incur a late fee for balances not paid within 60 days, unless written financial arrangements have been established. I understand a service charge for missed appointments may incur at the office's discretion for missed appointments or appointments cancelled without 24 hour notification.

**Signature:** _____________________________________________________ **Date:** _____________________________

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What brought you to the dentist today: ____________________________________________________________

Are you currently in pain? Y N Please describe any current problems/symptoms: ________________________

______________________________________________________________________________________

What, if anything, would you change about your smile? _______________________________________________

Are you interested in whitening? ________ Do you feel your teeth could be straighter?_____________________

**Are you experiencing any of the following? Please circle all that apply:**

| Mouth | Teeth |
|---|---|
| Bleeding, sore gums | Loose Teeth |
| Unpleasant taste/Bad Breath | Sensitive to Hot |
| Burning tongue/Lips | Sensitive to Cold |
| Frequent blisters, lips/mouth | Sensitive to Sweets |
| Swelling/Lumps in mouth | Sensitive to Biting |
| Ortho Treatment (Braces) | Food Impaction |
| Biting Cheeks/Lips | Clenching/Grinding |
| Clicking/Popping Jaw | Shifting of Teeth |
| Difficulty opening/Closing jaw | Change in bite |

Please list allergies: ____________________________________________________________________

Please list all medications you are currently taking: ____________________________________________

______________________________________________________________________________________

**Are you being treated for or have you ever been treated for any of the following? Please circle all that apply:**

| | | | | |
|---|---|---|---|---|
| Alcohol/Drug Abuse | Chemotherapy | Heart Attack | Measles | Scarlet Fever |
| Allergies | Cerebral Palsy | Heart Disease | Migraine Headaches | Sinus Trouble |
| Anemia | Chest Pain | Heart Murmur | Mitral Valve Prolapse | Skin Rash |
| Arthritis | Circulatory Problems | Hepatitis Type ______ | Mumps | Shortness of Breath |
| Artificial Valve/Joint | Diabetes | Herpes | Nervous Problems | Stroke |
| Asthma | Dizziness | High Blood Pressure | Osteoporosis | Thyroid Problems |
| Bleeding Problems | Double Vision | HIV/AIDS | Pacemaker | Tobacco Use |
| Blood Transfusion | Eating Disorder | Implant/Transplant | Pregnancy | Tuberculosis |
| Bronchitis | Emphysema | Kidney Disease | Psychiatric Care | Tumors/Growths |
| Cancer | Epilepsy/Seizures | Liver Disease | Radiation Therapy | Ulcer |
| Canker Sores | Glaucoma | Low Blood Pressure | Rheumatic Fever | Venereal Disease |

Please list any medical condition not listed above: _________________________________________________

Have you been hospitalized/had surgery in the last 5 years? Please describe: ___________________________

______________________________________________________________________________________

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that is it my responsibility to inform the office of any changes in my medical status.

**Signature:** ____________________________________________________________ **Date:** ________________

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**NOTICE OF PRIVACY PRACTICES:**
**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2002, and will remain in effect until we replace it.

**USES AND DISCLOSURES OF HEALTH INFORMATION:**
We use and disclose health information about you for treatment, payment and healthcare operations. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use or disclose your health information to obtain payment for services we provide you. We may use and disclose your health information with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications certification, licensing or credentialing activities.

**Signature:** ____________________________________________________________ **Date:** ______________________

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**HIPAA Compliance:**
In compliance with the Federal HIPAA policy, we are requesting your permission to send out appointment reminders postcards to the address on file. These postcards will have your name, address, time, and date of the appointment viewable by the post office.

______ I give Tamarac Dental Care permission to send appointment reminders via postcards
______ I would prefer another form of appointment reminder:

E-mail: _________________________________________________________________
Cell: ___________________________________________________________________

**Signature:** ____________________________________________________________ **Date:** _______________________

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**For Office Use Only**

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

____ Individual Refused to sign
____ Communication barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining the acknowledgement
____ Other (please specify)