IMPLANT & GENERAL DENTISTRY OF NORTHERN COLORADO

Ted E. Mioduski, Jr., D.D.S., P.C.
Nicole M. Ferrara, D.D.S., P.C.
Theo E. Mioduski, III, D.D.S., P.C.

• General Dentistry • Implants
• IV Sedations • Esthetic Dentistry
• TMJ/Craniofacial Pain • Snoring/Sleep Apnea

Sundance Professional Centre
2975 Ginnala Drive #100
Loveland, Colorado 80538
Fax (970) 663-0615
(970) 663-1000

Welcome! We are pleased to have the opportunity to treat your dental needs.

PATIENT NAME_____ ☐Male ☐Female
Last First MI

ADDRESS_____

PHONE - H#_____ C#_____ W#_____ EMAIL _____

DATE OF BIRTH _____ AGE_____SOCIAL SECURITY # _____ MARITAL STATUS _____

EMPLOYER NAME & ADDRESS_____OCCUPATION _____

NAME OF SPOUSE/PARTNER _____ ☐Male ☐Female DATE OF BIRTH_____

☐ **CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

PLEASE INDICATE HOW YOU PREFER WE CONTACT YOU REGARDING APPOINTMENTS, INSURANCE, FINANCES, PRESCRIPTIONS:

CHECK ALL THAT APPLY ☐HOME# ☐CELL# ☐WORK# ☐ EMAIL MAY WE TEXT YOU? _____

PLEASE LIST ANYONE AUTHORIZED TO RECEIVE INFORMATION REGARDING YOUR DENTAL APPOINTMENTS, CARE AND FINANCES:

_____

PERSON RESPONSIBLE FOR THIS ACCOUNT: Please check one: ☐ Patient ☐Spouse ☐Mother ☐Father ☐ Guardian
COMPLETE THIS SECTION IF OTHER THAN PATIENT

NAME_____ ☐Male ☐Female DATE OF BIRTH_____

ADDRESS_____ SOCIAL SECURITY # _____

PHONE - H#_____ C#_____ W#_____ EMAIL _____

EMPLOYER NAME _____OCCUPATION_____

DO YOU HAVE DENTAL INSURANCE? ☐YES ☐NO *IF YES, PLEASE COMPLETE THE FOLLOWING SECTION & PROVIDE ID CARD*

NAME OF INSURED_____ ☐Male ☐Female DATE OF BIRTH_____

EMPLOYER_____ RELATIONSHIP TO PATIENT_____

INSURANCE COMPANY_____MEMBER ID or SOCIAL SECURITY #_____GROUP #_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

WERE YOU REFERRED TO A SPECIFIC PROVIDER IN OUR PRACTICE? _____

DO YOU HAVE FAMILY MEMBERS ALREADY IN OUR PRACTICE? _____

The information I have provided is accurate to the best of my knowledge. I hereby consent to Implant & General Dentistry of Northern Colorado (IGDNC)'s use of my personal, dental and health information for the purposes of treatment, payment and/or health care operations. I understand this information serves as a basis for planning my care and treatment, a means for communication among my healthcare professionals and facilities who contribute to my care, a means by which a third party payer can verify that services billed were accurately provided, and a means by which IGDNC can contact me regarding my appointments through a 3rd party communication service, using my email address and phone numbers as indicated, for appointment confirmation and correspondence. I authorize and request my insurance company to pay IGDNC and its providers directly for billed services. I understand my insurance carrier may pay less than the billed amount and I am ultimately responsible to pay for all billed services regardless of my available insurance benefit.

I understand it is solely my responsibility to update IGDNC with any changes to my information. I understand that providing incomplete or inaccurate information can be dangerous to my health.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by HIPAA rules and regulations. I am aware I have the right to access my protected health information. My signature also acknowledges that I have read, understood and been offered a copy of Implant & General Dentistry of Northern Colorado's "Notice of Privacy Practices" statement. This consent provides that I may revoke this consent at any time, provided my request is made in writing to IGDNC. I certify that I have read and understand this authorization, release and consent.

SIGNATURE _____DATE _____

RELATIONSHIP TO PATIENT (if signed by responsible party) _____

REVIEWED BY_____ DATE_____

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MEDICAL HISTORY

PATIENT NAME:_____ DOB:_____

AGE:_____ HEIGHT: _____ WEIGHT: _____ □Male □Female

Name & location of Family Physician: _____ Date of last physical exam: _____

Are you in good health? □Yes □No *(please describe any concerns)*

_____

Have you had changes in your health in the last year? □Yes □No *(if Yes, please describe)*

_____

Are you currently under a physician's care for a particular concern? □Yes □No *(if Yes, please describe)*

_____

Have you ever had serious illnesses, surgery, or hospitalizations? □Yes □No *(if Yes, please describe and provide dates)*

_____

_____

Do you have, or have you had: ***(Please circle all that apply)***

Heart Disease	Stroke/TIA	Heart Murmur	Rheumatic Fever	Arthritis	Depression/Anxiety
High Blood Pressure	Diabetes	Seizures/Epilepsy	Fainting	Anemia	Psychiatric Therapy
Cancer/Tumor	Radiation Therapy	Chemotherapy	Ulcers/Colitis	Reflux/Gerd	Thyroid Disease
Blood Disease	Bleeding Disorders	Liver Disease	Hepatitis __	Bone Disease	Eye Disease
Joint Replacement	Implants	Venereal Disease	Herpes	AIDS/HIV	OTHER:_____
Sleep Apnea/Snoring	TMJ (Jaw Joint) Pain	Clicking of Jaw	Hysterectomy	Kidney Disease	_____
Asthma/Emphysema	Lung Disease/COPD	Tuberculosis	Sinus Trouble	Allergies	_____

Details: _____

Do you use Marijuana? frequency _____ Do you use Alcohol? frequency _____ Do you use Tobacco? *Smoke or Chew frequency*_____

Women: Are you Pregnant or is there a chance you may be? _____ Due Date _____ Currently Nursing? _____ Post Menopause? _____

Are you allergic or sensitive to these drugs or products?

Latex Antibiotics Penicillin Sulfa Aspirin Doxycycline Tetracycline NSAIDS OTHERS_____

List all Medications, Herbal Remedies, Vitamins, Alternative Medicine, Over the Counter Drugs, etc., you are currently taking:

_____

_____

Preferred Pharmacy _____

Treatment Authorization, Release and Consent:

I consent to treatment as necessary or desirable to care for me, for diagnosis of dental disease, deformity, or treatment of dental emergency. These procedures may include radiographs, models, photographs, and intraoral examination. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me during the period of such dental care, to third party payors and/or health practitioners. I authorize and request my insurance company to pay benefits, otherwise payable to me, directly to Implant & General Dentistry of Northern Colorado (IGDNC). I understand my insurance carrier may pay less than the fees I incur. I am responsible to pay all fees incurred on my behalf, regardless of insurance benefit. I understand it is my sole responsibility to report any changes in the information I have provided, including dental/medical history, insurance plan/carrier, and contact information.

I hereby consent to Implant & General Dentistry of Northern Colorado (IGDNC)'s use of my personal, dental and health information for the purposes of treatment, payment and/or health care operations. I understand this information serves as a basis for planning my care and treatment, a means for communication among my healthcare professionals and facilities who contribute to my care, a means by which a third party payer can verify that services billed were accurately provided, and a means by which IGDNC can contact me regarding my appointments through a 3rd party communication service, using my email address and phone numbers for appointment confirmation and correspondence. The information I have provided is accurate to the best of my knowledge. I understand that providing incomplete or inaccurate information can be dangerous to my health.

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RELATIONSHIP TO PATIENT (if signed by responsible party) _____

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DENTAL HISTORY

PATIENT NAME:_____

DOB:_____ AGE:_____ □Male □Female

Name & location of previous Dentist: _____

Date of last Dental Exam_____ Have you had regular dental checkups? _____

Have you had recent changes in your oral health? □YES □NO *(if Yes, please describe)*

_____

Have you been prescribed Premed Antibiotics for Dental procedures? □YES □NO *(if Yes, name of medication and reason for taking)*

_____

What are we seeing you for today? _____ What are your main dental concerns? _____

Do you have a specific problem which needs attention now? _____

Are you apprehensive about dental treatment? _____ Have you had serious complications with past dental treatment? _____

Are you interested in having IV or Oral Sedation for dental treatment? _____

Have you or a family member had problems with IV Sedation? *(if Yes, please describe)* _____

Have you been told you have a gum problem? *(if Yes, please describe)* _____

Have you lost many teeth? _____ Are you interested in dental implants? _____

Do you think you will eventually lose all your teeth? *(if Yes, please explain)* _____

Are you interested in receiving information on treatment options for Sleep Apnea or TMJ pain? _____

Treatment Authorization, Release and Consent:

I consent to treatment as necessary or desirable to care for me, for diagnosis of dental disease, deformity, or treatment of dental emergency. These procedures may include radiographs, models, photographs, and intraoral examination. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me during the period of such dental care, to third party payors and/or health practitioners. I authorize and request my insurance company to pay benefits, otherwise payable to me, directly to Implant & General Dentistry of Northern Colorado (IGDNC). I understand my insurance carrier may pay less than the fees I incur. I am responsible to pay all fees incurred on my behalf, regardless of insurance benefit. I understand it is my sole responsibility to report any changes in the information I have provided, including dental/medical history, insurance plan/carrier, and contact information.

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PATIENT_____ DATE_____

RESPONSIBLE PARTY_____ PHONE _____

OFFICE FINANCIAL POLICY

Our experience has shown it is helpful to have an understanding with our patients as to our office financial policy. Please read the following information thoroughly. We are available to address any questions you may have.

For your convenience we offer several methods of payment for your dental care including cash, personal check, Visa, MasterCard, Discover, Care Credit and dental insurance.

DENTAL INSURANCE

As a courtesy to our patients, we will submit dental claims for you and in many cases we accept assignment of benefits to receive payment directly from your insurance company. We ask that you provide us with a copy of your dental plan prior to your first appointment along with current insurance I.D. information. This allows our office to help you determine your benefits. Some procedures may require written predetermination prior to beginning treatment. All dental services may not be a covered benefit of your insurance. We encourage you to be familiar with of your insurance plan's benefits. Patients are ultimately responsible for the discovery and understanding of the limitations of their insurance plan.

PAYMENT OF YOUR INSURANCE DEDUCTIBLE AND THE PERCENTAGE OF TREATMENT NOT COVERED BY YOUR INSURANCE PLAN WILL BE EXPECTED AT THE TIME SERVICES ARE RENDERED. DENTAL INSURANCE IS A CONTRACT BETWEEN THE PATIENT, THE EMPLOYER, AND THE INSURANCE CARRIER; NOT BETWEEN THE DENTIST AND THE INSURANCE CARRIER. THUS, PATIENTS ARE ULTIMATELY RESPONSIBLE TO THIS OFFICE FOR ALL FEES AND FINANCIAL CHARGES INCURRED REGARDLESS OF THE INSURANCE COMPANY'S BENEFIT POLICY.

FINANCE CHARGE & COLLECTIONS

A FINANCE CHARGE of 1.5% per month (18% Annual Percentage Rate) will be added to your account on the unpaid balance after 60 days. This same finance charge will apply to insurance benefits pending or delayed past 60 days. You may avoid a finance charge by paying for services as they are rendered. In the event a patient's account is turned over to a collection agency for failure to abide by these financial terms, the patient will be liable for all collection fees, attorney fees, and court costs. The occurrence of an account being forwarded to a collection agency may result in dismissal from our practice.

CANCELLATION & FAILURE POLICY

Appointment failures and appointment cancellations with less than 48 hours notice will result in a minimum $50.00 charge to the patient. Multiple failures or cancellations may result in dismissal from our practice.

RETURNED CHECK POLICY

Any check returned from the bank for "insufficient funds" will result in a $50.00 charge to the patient.

RELEASE OF RECORDS

A signed "AUTHORIZATION TO RELEASE DENTAL INFORMATION" will be required for any and all requests for patient records. A formal practice dismissal may follow.

TREATMENT PLAN & FEE ESTIMATES

The estimated treatment plan and the approximate fees may be prepared for your review. Fees are guaranteed for 90 days from this date. I understand that the final fees may vary from this estimate depending upon the length of time I have selected (or the actual length of time necessary) to complete this treatment plan. Our fees are updated periodically and thus your final fees may vary from a previous estimate or an insurance pre-authorization depending upon the time frame between the pre-authorization and actual treatment. It is not always possible to diagnose every potential dental problem, even with x-rays. Thus, the need for additional procedures, x-rays, or treatment may arise as we proceed with the original findings.

FINANCIAL AGREEMENT

I authorize the release of any information acquired during the course of my treatment necessary to process insurance claims.

I hereby authorize payment of dental benefits, otherwise payable to me, to be made directly to this office.

I have read the financial agreement completely and understand the above financial policy. I agree to abide by this policy and conditions as stated. I understand that I am ultimately responsible to this office for ALL fees and financial charges incurred regardless of my insurance benefits. I have received a copy of this office's "Notice of Privacy Practices".

Please Print Name	Signature (Patient, or Responsible Party)	Date
Office Staff	Signature	Date

Ted E. Mioduski, Jr., D.D.S., P.C. Nicole M. Ferrara, D.D.S., P.C. Ted E. Mioduski, III, D.D.S., P.C.

Implant & General Dentistry of Northern Colorado

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.

OUR LEGAL DUTY

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 January 1, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose, to military authorities, the health information of Armed Forces personnel under certain circumstances. We may disclose, to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text messages, postcards, or letters).

PATIENT RIGHTS **Access:** You have the right to look at or get copies of your health information, with limited exceptions. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.20 for each page, $45 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officers: Ted E. Mioduski Jr., D.D.S., P.C. Nicole M. Ferrara, D.D.S., P.C. Ted E. Mioduski, III, D.D.S., P.C.

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