NORTHERN COLORADO IMPLANT
AND PROSTHETIC DENTISTRY

NCIPD

Andrew J. Bock, D.D.S.

Northern Colorado Implant and Prosthetic Dentistry

Welcome! We are pleased to have the opportunity to treat your dental needs. Please fill out the information sheets for our records.

PATIENT INFORMATION

Name: _____ Date: _____ Birth Date: _____ Age: _____

Address: _____ Email: _____

City/State/Zip: _____ Social Security #: _____

Occupation: _____ Male ☐ Female ☐ Marital Status: _____

Employer: _____ Phone (H) _____ Phone (M) _____

Employment Address: _____ Phone (W) _____

Referred By: _____ IN CASE OF EMERGENCY, PLEASE CONTACT: _____

Do you have dental insurance? _____ PERSON RESPONSIBLE FOR THIS ACCOUNT: _____

SPOUSE OR PARENT

Name: _____ Birth Date: _____ Social Security #: _____

Employer: _____ Occupation: _____

Phone #'s _____

DENTAL INSURANCE INFORMATION

Insurance Company Name: _____ Insurance Group #: _____

Employee Name: _____ Employer Name: _____

Employee Social Security #: _____ Employee Birth Date: _____

Employee User ID#: _____ Relationship to Patient: _____

Insurance Company Address _____ Insurance Company Phone # _____

INSURANCE INFORMATION RELEASE:

I, the undersigned, have insurance coverage and the payment will be sent to me for services rendered. **I understand I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Date: _____ Signed: _____

DENTAL HISTORY

1. Chief complaint: _____
2. Have you had regular check-ups? _____
3. When was your last dental visit? _____
4. Have you lost many teeth? (If YES, why?) _____
5. Do your gums bleed when brushing or flossing? _____
6. If you wear dentures or partials, how old are they? _____
7. Are you apprehensive about receiving dental treatment? _____
8. Any complications during previous dental treatments? _____

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Patient Name Date:

MEDICAL HISTORY

Name of family Physician: _____ Telephone # _____

Physician's Address _____

Do you have, or have you had, any of the following? (Please check all that apply)

☐ Heart Disease	☐ Seizures	☐ Thyroid Disease	☐ Lung Disease	☐ Psychiatric Therapy
☐ High Blood Pressure	☐ Fainting	☐ Anemia	☐ Tuberculosis	☐ Kidney Disease
☐ Artificial Heart Valves	☐ Arthritis	☐ Blood Disease	☐ Asthma/Emphysema	☐ Venereal Disease
☐ Rheumatic Fever	☐ Ulcers	☐ Bleeding Disorder	☐ Allergies	☐ Joint Replacement
☐ Heart Murmur	☐ Tumor History	☐ Hepatitis	☐ Sinus Trouble	☐ Cough
☐ Stroke	☐ Radiation Therapy	☐ Liver Disease	☐ HIV/AIDS	☐ Epilepsy
☐ Diabetes	☐ Chemotherapy	☐ Bone Disease	☐ Hysterectomy	☐ Latex Allergy

Do you use alcohol? _____ Do you use tobacco? _____

☐ YES ☐ NO Have you ever been hospitalized and/or had surgery? (If yes, please list most recent:)

When: _____ Why: _____

When: _____ Why: _____

☐ YES ☐ NO Are you under the care of a physician now? Explain _____

_____

☐ YES ☐ NO Are you taking medication, drugs, pills, vitamins or herbal supplements? (If YES, list) _____

_____

☐ YES ☐ NO Are you allergic or sensitive to aspirin, penicillin, or any other drugs or medicine? Explain _____

_____

☐ YES ☐ NO Have you ever been treated for cancer with an I.V. drug like Zometa or Aredia?

☐ YES ☐ NO Have you ever taken Fosomax or a bisphosphonate drug? If yes, for how long? _____

☐ YES ☐ NO Do you have any disease, condition, or problem not listed above? (If YES, list) _____

☐ YES ☐ NO Have you ever had any excessive bleeding requiring special treatment?

☐ YES ☐ NO Have you ever had a blood test for hepatitis? If so, were you vaccinated? ☐ yes ☐ no

☐ YES ☐ NO Have you had cankers or cold sores on your lips, tongue, gums or body?

☐ YES ☐ NO If female, are you pregnant now? Delivery Date _____ Post Menopause? _____

☐ YES ☐ NO If female, are you nursing?

☐ YES ☐ NO Have you been out of the United States in the past 6 months? Where? _____

I consent to treatment as necessary or desirable to care of the patient first named above, for diagnosis of dental disease, deformity, or treatment of dental emergency. In case of dental emergency, I consent to treatment, as deemed necessary by the doctor, understanding the procedures will be explained in advance. I understand it is solely my responsibility to report any changes in the above information to this office. I consent to my x-rays and dental records being sent to my general dentist and my general dentist sending x-rays and dental records to Dr. Bock for his use.

Signed: _____ Date: _____ _____

Patient / Parent / Guardian Andrew J. Bock, D.D.S.

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970-669-6670

COMMITMENT TO APPOINTMENT

Your name in our appointment book is a bond of trust. It represents a mutually understood agreement that you will be present for your appointment and that we will be here to serve you. Our office is very firm in this regard, and we will not tolerate frequent cancellations or short notice changes. We certainly understand that, on occasion; circumstances do arise that prevent patients from keeping scheduled appointments. We do request that, if you find you will be unable to keep an appointment with our office, you will give us at least 48 hours notice. This will allow us time to fill your appointment with another patient. **Failed/no show appointments may be assessed a charge.** Patients who are more than 10 minutes late for their appointment may be rescheduled.

COMMITMENT TO FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

- Payment is due at the time of service.
- If insurance is involved, we will be happy to submit claims for you and the payment will be sent to you.
- Because every insurance plan is different, we do request full payment for initial/ new patient exams on the date of service.

Your treatment plan/recommended treatment will be pre-authorized with your insurance company. We encourage you, the patient, to follow up on pre-authorizations, and delayed insurance payments.

**We accept cash, check, MasterCard, Visa, Discover and Care Credit.

Dental insurance should be regarded as dental assistance. It is designed to help you pay ***some*** of the cost of dental treatment. Because there are so many dental insurance companies and programs, it is nearly impossible for us to have complete knowledge of all of them. We will do our best to help you maximize your benefits. Dental insurance is meant to be a partial aid to defray professional fees. It is not designed to cover the entire cost of dental treatment.

Insurance is a contract between you and your insurance company. We are typically not a party to this contract. We file insurance as a courtesy to our patients. We are not required to become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, or other matters regarding reimbursement. The kind of benefits in your contract depends on what you or your employer has negotiated with the insurance carrier, and the amount of money that you choose to pay in premiums.

I understand that I am responsible for all costs of dental treatment regardless of what my insurance carrier may or may not pay.

Patient _____ Date _____

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Northern Colorado Implant and Prosthetic Dentistry Privacy Notice

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 970-669-6670.

*Information We Collect About Yo*u

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. NCIPD does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

NCIPD maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with NCIPD.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. NCIPD occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

I _____ have reviewed Northern Colorado Implant and Prosthetic Dentistry Privacy Policy.

Signed _____Date_____