Boulder Periodontics Patient Information

Patient Information

First and Last Name _____ Date of Birth _____
Mailing Address _____
City _____ State_____ Zip_____
Cell Phone _____ Home Phone_____
Email _____ Sex: □M □F
Referring Doctor Name _____
Preferred Pharmacy Name and Location _____

Dental Insurance

Dental Insurance Company _____
Claims Mailing Address for Insurance _____
Name of Policy Holder _____ Policy Holder DOB _____
Policy Holder Relation to Patient _____ Policy Holder SSN _____
ID # _____ Group # _____ Employer _____

Financial Policies

We are **OUT OF NETWORK** with your dental insurance company so please confirm that you are free to see the provider of your choice. Payment is expected at the time the services are rendered. Evaluations are to be paid in full at time of service. We will collect one third payment at time of surgeries. You are responsible for knowing your insurance coverage and limitations of your plan (such as yearly maximums and deductibles). You have 90 days to pay your bill regardless of the status of your insurance claim. If the entire balance is not paid within 90 days, a service charge will accrue monthly. We are not a medical office and therefore do not submit to medical insurance. Please be aware, we are not a Medicare/Medicaid provider. We accept Visa, MasterCard, Discover, Care Credit, Checks and Cash. We kindly ask for 24 hours when rescheduling or canceling a cleaning appointment and 72 hours for scaling and rootplaning or surgical appointment. A charge may be applied for an appointment that is not rescheduled within this time frame or has been rescheduled twice.

By signing below, I agree to the terms and conditions above and listed on the financial policy sheet provided to me, and will assume full responsibility for any and all changes incurred at Boulder Periodontics.

Signature: _____ Date: _____

HIPAA

Notice of Privacy Practices Acknowledgement

By signing below, you are acknowledging office HIPPA Policies, which are presented on the front office counter.

Please Print Name:_____
Signature: _____
Date: _____

FOR OFFICE USE ONLY:

We attempted to obtain an acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited signature
- Emergency situation prevented acknowledgement
- Other

Boulder Periodontics Medical History

Name:_____ DOB:_____ Phone Number:_____

Are you allergic to any of the following?
□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □Local Anesthetics Iodine/Shellfish
□ Other:_____

ARE YOU:

Currently under a physician's care?..... □
Specify: _____
A smoker or tobacco user? ..... □
Specify: _____
On a special diet?……..... □
Specify: _____
Taking any Phen-Fen or Redux? …..…..□
WOMEN: Pregnant or Nursing?..... □
WOMEN: Taking oral contraceptives?.... □

IN THE LAST 5 YEARS HAVE YOU:

Been hospitalized? ……..…… □
Specify:_____
Had a major operation ……..... □
Specify:_____
Have you had a recent Vitamin D level? Y/N
Level _____ng/ml <10ng/ml Y/N

HAVE YOU EVER TAKEN:

Bisphosphonates for bone density:
Prolia/Fosamax/Actonel/Reclast, etc…
(Please Circle Any That Apply)
Premedications for dental visits?_____

DO YOU TAKE:

Aspirin _____ Fish Oil _____
Blood Thinners _____
Reclast/Prolia/Fosamax/Actonel
(Please Circle Any That Apply)
Ginseng, Garlic, Ginkgo, or Valerian?
(Please Circle Any That Apply)
CBD Oil or similar products? _____
Vitamin D? _____
Premedications for dental visits? _____

MEDICAL HISTORY:

Anemia……..…… □
Arthritis ……..…… □
Specify: _____
Artificial Heart Valve…….. □
Artificial Joint: ……..……□
Right/Left: _____
Asthma ……..……□
Blood Disorder…….. … □
Bruise Easily……..……..□
Chest Pains……..…… □
Cold Sores……..…… □
Cancer…… □
Specify:_____
Chemotherapy……....□
Radiation Treatments.….□
Congenital Heart Disorder...□
Diabetes:……..…… □
Specify: I, II, or III
Drug Addiction……..…… □
Emphysema……..... □
Epilepsy/Seizures……..… □
Frequent Headaches…..... □
Glaucoma……. □
GERD……..…… □
Gout ……..…….. .□
HIV Positive……..... .□
Heart Attack/Failure…..… ..□
Heart Murmur…….. ...□
Heart Pace Maker……..…. □
Heart Disease……...……□
Hemophilia……..…...…..…□
Hepatitis: ……...□
Specify: A, B, or C
High Blood Pressure…..……□
Hypoglycemia……..……□
Digestive Disease……□
Specify:_____
Irregular Heart Beat……□
Specify: _____
Jaw Joint Clicking or Pain…...□
History of TMJD Treatment….□
Kidney Problems…… □
Leukemia……..…□
Liver Disease…….…....…..□
Low Blood Pressure……....□
Mitral Valve Prolapse……..□
Osteoporosis……..…..□
Osteopenia……...□
Parathyroid Disease……□
Psychiatric Care……...□
Recent Weight Gain/Loss……□
Shingles……..□
Sinus trouble……..□
Stroke……..□
Thyroid Disease……...□
Tuberculosis……..□
Ulcers……..……□

Any other illness/syndrome not listed above?

_____
_____
_____

PLEASE LIST ALL MEDICATIONS YOU TAKE:
(including over the counter, herbal, or minerals)

_____
_____
_____
_____
_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications you may be taking have an important interrelationship with the dentistry you will receive. I understand that providing incorrect information can be dangerous to my (or patient's) health. Thank you for answering these questions!

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ **DATE**_____
Reviewed by Dr._____

BOULDER PERIODONTICS
SPECIALISTS IN PERIODONTOLOGY
Implants • Oral Medicine

Insurance

We are an **OUT OF NETWORK PROVIDER**. We will submit claims to all dental insurance companies, but there may be a difference in your coverage with us. Dental insurance rarely covers treatment in full and may be subject to in versus out of network allowances and yearly maximums. We submit all claims on your behalf, as well as treatment plans from the doctors for pre-determination. Please note, we file insurance as a courtesy to our patients, but it is the patient's responsibility to know insurance coverage. We submit to dental insurance only. We are a not a medical office and therefore do not submit to medical insurance, or Medicaid/Medicare. If a payment is made for a procedure by insurance the patient will be reimbursed directly from the insurance company. We do not routinely call your insurance company as they may not be able to disclose your personal information to us. *Please feel free to request to speak to our financial coordinator anytime if you have additional questions!*

Payment Options

It is our goal to help make periodontal treatment affordable for everyone. While payment is due at the time services are rendered, we do offer 90 day, no interest financing for certain services. We have listed the policies below:

- **Consultations & Examinations**: Payment is due at the time services are rendered.
- **Surgeries, Cleanings, Procedures & Scaling and Root Planing**: A minimum of one-third payment at the time of surgery. The remainder of the balance is due within the 90 day period.
- We accept the following forms of payment:
  - Credit & Debit Cards: Visa, MasterCard, and HSA cards
  - Cash or Check
  - Care Credit is our medical/dental third party financing option. We pay your interest so you may apply for their 6 month, no-interest financing plan. You may apply for an account online at www.carecredit.com . Surgeries must be paid in full if using Care Credit, and the minimum we require for each Care Credit transaction is $700; if your balance due is below this amount, we ask that you choose another payment method.
- Billing: We send out monthly bills to all accounts with balances. If the balance is not paid within 90 day of services rendered an 18% finance charge per month will be added to any unpaid balance until paid in full. Boulder Periodontics charges $40 for returned checks

Cancelation Policy

We kindly request 48 hours' notice for the rescheduling of a cleaning appointment, and 72 hours' notice for the rescheduling of a scaling and root planing or surgical procedure. There may be a charge of up to the total cost of a visit for a missed or cancelled appointment within this time frame or for an appointment which has been moved twice. We kindly remind you that it is your responsibility to know the date of your appointment regardless of our automated reminder system. INITIAL: _____

By signing below, you are acknowledging office financial and cancellation policies.

Patient Name: _____

Patient Signature: _____ Date: _____