

# WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

As required by law, our office adheres to written policies and procedure to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you.

## Patient Information

How would like us to address you? \_\_\_\_\_  
Name \_\_\_\_\_ Soc.Sec. # \_\_\_\_\_  
Last Name First Name Initial  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home phone \_\_\_\_\_ Cell  
Phone \_\_\_\_\_ Email \_\_\_\_\_  
Sex: M F Age \_\_\_\_\_ Birthday \_\_\_\_\_ Single Married  
Patient Employed by \_\_\_\_\_  
BusinessAddress \_\_\_\_\_ BusinessPhone \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
If yellow pages, Red book \_\_\_\_\_ or Yellow book \_\_\_\_\_  
Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell phone \_\_\_\_\_ Business Phone \_\_\_\_\_

## Responsible Party

Person responsible for account \_\_\_\_\_ Birth date \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ S.S.# \_\_\_\_\_  
Address (if different from patient) \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_ phone \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Phone \_\_\_\_\_  
Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

## Medical History

Physician's name \_\_\_\_\_  
Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations?  
Y N

If yes, please explain: \_\_\_\_\_

When was your last dental cleaning? \_\_\_\_\_

Have you taken, currently taking, or scheduled to take either of the medications: Alendronate (Fosamax), or Risedronate (Actonel) for osteoporosis or Paget's Disease? Y N

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zomeda) for bone pain, hypocalcaemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Y N Dates treatment began; \_\_\_\_\_

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Y N If yes, when: \_\_\_\_\_

Do you use any tobacco products (smoking, chewing, snuff, etc.)? Y N If yes, how much: \_\_\_\_\_

Are interested in SEDATION? or RELAXATION dentistry? Y N

If you rated you smile from 1 – 10, what would it be (1=poor, 10=fantastic)? \_\_\_\_\_

Would you like to improve your smile? Y N

Circle yes or no whether you have had or have any of the following:

Y N AIDS/HIV positive	Y N Diabetes, I or II	Y N Jaw pain	Y N Dry mouth
Y N Anaphylaxis	Y N Epilepsy	Y N Kidney disease or malfunction	Y N Skin rash
Y N Arthritis/Rheumatism	Y N Fainting	Y N Liver disease	Y N Stroke
Y N Artificial heart valves	Y N Food allergies	Y N Material allergies	Y N Surgical implant
Y N Artificial joints	Y N Glaucoma	Y N Headaches/Migraines (latex, wool, metal, or ankles)	Y N Swelling of feet
Y N Asthma	Y N Heart problems	Y N Pacemaker/	Y N Thyroid condition
Y N Anemia/Blood disease	Describe _____	Y N Heart Attack/	Y N Angina
Y N Cancer/Chemotherapy/ Radiation Treatment	Y N Damaged Heart Valves	Y N Heart surgery	Y N Autoimmune Disease
Y N Chemical Dependency	Y N Hemophilia/ Abnormal bleeding	Y N Psychiatric care	Y N Tobacco habit
Y N Chemotherapy	Y N Herpes	Y N Radiation treatment	Y N Tuberculosis
Y N Cardiovascular Disease	Y N Hepatitis, Type _____	Y N Shortness of breath	Y N Ulcer/Colitis
Y N Cortisone Treatments	Y N High Blood Pressure	Y N Systemic Lupus Ery.	Y N Venereal disease
Y N Congestive Heart Failure	Y N Blood Transfusion	Y N Emphysema	Y N Chest pain upon exertion
Y N Congenital Heart Defects	Date: _____	Y N Gastrointestinal Disease	
Y N Eating Disorder	Y N Neurological Disorder, if yes please specify: _____		
Y N Reflux/ Heartburn	Y N Osteoporosis	Y N Severe or rapid weight loss	
Y N Kidney Problems			

Women : Is there any chance you are pregnant?: Y N Are you nursing? Y N Taking birth control pills? Y N

What medications are you taking?  
have?

What allergies (drug & environmental) do you have?

\_\_\_\_\_  
\_\_\_\_\_

What dietary supplements are you taking (vitamins, herbal, etc.)? \_\_\_\_\_

Do you have any disease, condition, or problem not listed above that we should be aware of?

Please explain: \_\_\_\_\_

### Authorization

I certify I have read and understand the information given on this form is accurate. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of error or omissions that I may have made in the completion of this form

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at time of treatment, unless prior arrangements have been approved.**

Mason O. Miner, DDS, LLC

72 Suttle Street, Suite H

Durango, CO 81303

Phone: (970) 247-2677

With my consent, Dr. Miner may use and disclose protected health information about me to carry out treatment, payment, consultation, and healthcare operations. Please see Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, the office of Dr. Miner may:

\_\_\_\_\_ call my home

\_\_\_\_\_ call my work

\_\_\_\_\_ call my cell phone

\_\_\_\_\_ call or send appointment reminders

\_\_\_\_\_ Communicate via e-mail

\_\_\_\_\_ consult supervising physician or health care providers to which I am referred

\_\_\_\_\_ mail my home

\_\_\_\_\_ I do authorize my clinical information/lab results to be transferable throughout the office and available or consultation with office staff.

By signing this form, I am consenting to the office of Dr. Miner to use and disclose my protected health information. I may revoke consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent Dr. Miner may decline to provide treatment to me.

**Signature of Patient:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

Date: \_\_\_\_\_

Receipt of Notice of Privacy Practices  
Written Acknowledgement Form

I, \_\_\_\_\_ have read and understand Dr. Miner's Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

# OFFICE POLICIES

Thank you for choosing Mason O. Miner, DDS, LLC. Our mission is providing to you, your family and friends the very best dental care. Please read the following guidelines carefully.

1. Scheduled appointments: Please plan to arrive 10 minutes in advance of your scheduled appointment. Our professional staff is trained to promptly assist you. If you are unable to keep a scheduled appointment, please call us at 247-2677 at least 24 hours prior to enable us to reschedule your appointment. We reserve the right to charge a fee for late cancellations or missed appointments. If a personal emergency arises please call Dr. Miner on his cell phone (number available on recording).
2. Payment policy: Patient/guarantor agrees to pay all charges and fees on date of service. Please discuss special needs and payment options with our Office Manager in advance. A 15% APR finance charge may be applied for any unpaid balance over 90 days. Unpaid balances will incur an additional 50% of the unpaid balance added to the account if assigned to a collection agency. Additional costs including any collection agency fees, attorney's fee, court and related cost will also be added.
3. Returned checks are subject to a \$25 charge.
4. Insurance: I understand that my insurance is an agreement between my insurance company and myself. I also understand that I am responsible for the balance of my dental account regardless of my insurance benefit. Co-payments on date of service are **estimates** only. I am responsible for claims not paid within 45 days of service.
5. As required by Colorado state law, if a prescription for a controlled substance is given, certain prescription information, including your name, be entered into a secure database (Colorado's Prescription Drug Monitoring Program) when you fill this prescription at your pharmacy. Authorized prescribers of controlled substances and law enforcement in limited circumstances may access the database for allowed uses.

I understand as the patient, guardian and/or parent; I am responsible for the entire balance of my account and for complying with terms of payment set forth.

By signing below, I accept the office policies as outlined above.

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Signature

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Name

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Date

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Physical address

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Mailing Address

TO OUR PATIENTS THAT HAVE INSURANCE:

WE ARE HAPPY TO HELP YOU WITH YOUR INSURANCE BY ANSWERING QUESTIONS TO MAXIMIZE YOUR BENEFITS, WHAT YOUR CO-PAY MAY BE, ETC. HOWEVER, YOU MUST UNDERSTAND THE FOLLOWING:

1. IT IS **YOUR** INSURANCE – WE DO NOT HAVE ACCESS TO YOUR INSURANCE COMPANY TO KEEP TRACK OF BALANCES OR ANY CHANGES IN COVERAGE. **THESE ARE YOUR RESPONSIBILITY.**
2. YOUR INSURANCE IS A CONTRACT BETWEEN **YOU AND THE INSURANCE COMPANY.** WE ARE NOT A PARTY TO THIS CONTRACT IN ANY WAY AND, IN FACT, OTHER THAN TO VERIFY COVERAGE, YOUR INSURANCE COMPANY WILL NOT DISCUSS YOUR ACCOUNT WITH US. SO, IF YOU HAVE ANY QUESTIONS ABOUT THE AMOUNT OF YOUR COVERAGE OR YOUR REMAINING COVERAGE, YOU MUST CONTACT YOUR COMPANY, AS WE CANNOT.
3. NOT ALL SERVICES ARE COVERED BY YOUR INSURANCE. SOME INSURANCE COMPANIES ARBITRARILY SELECTS CERTAIN SERVICES THEY WILL NOT COVER.

AGAIN, WE MUST EMPHASIZE THAT OUR RELATIONSHIP IS WITH YOU, THE PATIENT, NOT WITH YOUR INSURANCE COMPANY. WHILE WE WILL FILE YOUR INSURANCE FOR YOU AS A COURTESY, YOU NEED TO BE AWARE THAT **ALL CHARGES ARE YOUR RESPONSIBILITY.** ANY QUESTIONS YOU MAY HAVE AS TO EXTENT OF COVERAGE, DENIAL OF BENEFITS, OR OTHER COVERAGE QUESTIONS MUST BE DIRECTED TO YOUR INSURANCE COMPANY, NOT OUR OFFICE.

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PATIENT INITIALS