Patient Health Information

Legal Name:________________________________ Preferred Name:_____________________________

Address: ____

Birthdate:_______________________ **(Optional)** Gender Identity: ____________________ Pronouns: _________________

Phone: (home)__________________________ (cell)__________________________ (work)_____________________________

Email Address:____ Would you like email/text reminders? ❑Yes ❑No

---

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No Physician Name: ______________________________

Do you have a history of Heart Disease? ❑ Yes ❑ No

Please explain: ____

Have you ever had any surgical procedures? ❑ Yes ❑ No

Please list each one: ____

Are you taking or ever taken a Bisphosphonate medication like Fosomax, Zometa, Boniva, Aredia or Reclast? ❑ Yes ❑ No

Are you taking any medications? ❑ Yes ❑ No

Please list each one: ____

Do you use tobacco in any form? ❑ Yes ❑No

Please check if you have a history of any of the following:

Condition

- ❑ Abnormal Bleeding
- ❑ Acid Reflux
- ❑ Alcohol/Drug Abuse
- ❑ Allergies
- ❑ Arthritis/Autoimmune
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood Thinner
- ❑ Cancer/Chemo/Radiation
- ❑ Diabetes
- ❑ Frequent Headaches

Condition

- ❑ HIV+ Aids
- ❑ Heart Attack/Stoke:When?________
- ❑ High **or** Low Blood Pressure (**circle**)
- ❑ History of Eating Disorder
- ❑ Joint Replacement/Artificial
- ❑ Pacemaker
- ❑ Rheumatic Fever/ Endocarditis
- ❑ Seizures
- ❑ Sinus Problems
- ❑ Sleep Apnea/ Airway Issues
- ❑ High Cholesterol/Heart Disease

Allergies

- ❑ Aspirin
- ❑ Codeine
- ❑ Latex
- ❑ Penicillin
- ❑ Tetracycline
- ❑ Other: _______________

If Female,

- ❑ Are you taking birth control pills?
- ❑ Are you pregnant? # of weeks ______
- ❑ Are you nursing?

Are there any other conditions not listed above? ____

Please check if you have a history of any of the following:

- ❑ Bad breath
- ❑ Bad tastes
- ❑ Bite nails/objects
- ❑ Chew on one side
- ❑ Clenching/grinding teeth
- ❑ Clicking/popping of jaw
- ❑ Crowded teeth
- ❑ Difficulty chewing
- ❑ Dry mouth
- ❑ Gag easily
- ❑ Jaw/head/neck Pain
- ❑ Loose teeth
- ❑ Cold/Canker Sore/Ulcer
- ❑ Missing teeth
- ❑ Sensitive gums or bleeding gums
- ❑ Sensitive to: ❑Hot ❑Cold ❑Sweets
- ❑ Snoring
- ❑ Stained teeth
- ❑ Trouble Sleeping
- ❑ Wear a night guard or Appliance/CPAP

I understand that the information that I have given today is the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status.

Signature: ____ **Date:**________________________

SOUTH METRO DENTISTRY
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

I, ____ have received a copy of this office Notice of Privacy Practices.

____________________________	____________________________
Patient Name (print)	Person Authorized to Sign for Patient
____________________________	____________________________
Signature	Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

____

____

PATIENT RIGHTS

Access: You have the right to inspect and receive a copy of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. 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 in this Notice. We may charge you a reasonable cost based fee for expenses such as staff time, copies and postage if you want them mailed to you. You may also request access by sending us a letter to the address in this Notice. If you request an alternative format, we may charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed in this Notice for a full explanation of our fee structure.

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. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request that it include disclosures for treatment, payment or healthcare operations.

Restrictions: You have the right to request that we place additional restrictions on our use of 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.

NAME OF PRACTICE

South Metro Family Dentistry
6950 S. Holly Circle, Ste. 202
Centennial, CO 80112

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 this Notice about our privacy practices, and 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 took effect 04/14/03, and was amended 03/26/2013.

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 in this Notice.

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 of disclosure of your health information or to have us communicate with you by alternative means or locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the Office for Civil Rights. We will provide you with the address to file your complaint with the Office for Civil Rights 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 the Privacy Officer or with the Office for Civil Rights.

Privacy Officer: ______________________

Telephone: ______________________

Email: ______________________

Address: South Metro Family Dentistry
6950 S. Holly Circle, Ste. 202
Centennial, CO 80112

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201
Toll-Free Phone: 1-(877) 696-6775

This form does not constitute legal advice, and covers only federal—not state—law in effect as of April 14, 2003. This form revised as of March 26, 2013.

FORM #0076 © 2013 INFORMS 1-800-722-4884

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. You have a right to restrict disclosures of PHI to a health plan with respect to health care for which you (or your family or friends) have paid out-of-pocket in full.

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 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 with your written authorization.

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 of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 and/or Fund Raising:

We are prohibited from using or selling your health information for marketing communications without your written authorization. You also have the right to opt out of receiving any fundraising communications from us.

Required by Law:

We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

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 institution or law enforcement official having lawful custody or protected health information of inmate or patient under certain circumstances.

Breach:

We are required by law to notify you if there has been a breach of unsecured protected health information (PHI).

SOUTH METRO DENTISTRY
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OFFICE POLICY

Appointment Cancellation Policy
Your appointment time is reserved specifically for you. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. As a courtesy if you are unable to keep your appointment, please give at least one business days' notice. Otherwise, after two missed or less than one business day cancelled appointments, a deposit will be required to reschedule.

Authorization and Release
I authorize Dr. Morse and/or Dr. Rivera to release any information including the diagnosis and the records of any treatment or examination rendered during the period of such dental care to the third party payers (insurance providers) and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Morse and/or Dr. Rivera at South Metro Family Dentistry.

Insurance and Financial Arrangements
As a courtesy we offer you an estimate for recommended treatment. All estimated portions are due at the time of service, unless other arrangements are made. Cash, check and credit cards are accepted. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Our team of treatment coordinators are very effective at maximizing your insurance benefits. We will do everything in our power to get full payment from you insurance provider. We are happy to help answer any insurance plan questions that you have and we encourage you to refer to your benefits or call your insurance customer service.

Late Charges
If I do not pay the entire balance within 25 days of the monthly billing date, a late charge of 1.5% on the unpaid balance will be assessed each month. In the case of default on payment on this account, I agree to pay collection costs and reasonable fees incurred in attempting to collect on this amount or any future outstanding account balances.

Sign below in acceptance of this policy.

________________________________	________________________________
Patient Name (print)	Person Authorized to Sign for Patient
________________________________	________________________________
Signature	Date

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Emergency Contact Information

In the event of an emergency, who should we contact?

Name: ________________________ Relationship: _______________ Phone #: __________________

Dental Insurance Information

Primary Insurance:

Insurance Co:________________________________ Phone #:______________________________

Name of insured:_____________________________ Relation to insured:_____________________

Insured DOB:_________________________________ Insured SSN/ID#:________________________

Employer:____

Secondary Insurance:

Insurance Co:_______________________________ Phone #:______________________________

Name of insured:____________________________ Relation to insured:_____________________

Insured DOB:________________________________ Insured SSN/ID#:________________________

Employer:____

SOUTH METRO DENTISTRY
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General Consent for Treatment

I authorize Dr. Ian Morse and Dr. Nate Rivera or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility. This may include the arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not visible during examination. I give my permission to my dentist to make any/all changes and additions as necessary.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitive reactions.

I understand that we will make every effort to avoid jaw muscle soreness and tenderness but after lengthy appointments this may inevitably occur. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription or recreational drugs that are currently being taken or that have been taken in the past such as blood thinners or bisphosphonates. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fossamax, Boniva, or Actonel may result in complications of healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me verbally and I have been given the opportunity to ask questions.

Patient name: ____

Signature: ____ **Date**: _______________

Witness: ____ **Date**: _______________

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AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than the terms specifically described below.)

Patient Name: ____

Previous Dental Office Name: ____

Previous Dental Office Fax: ____________________ **Email:** ____________________

Release to: South Metro Family Dentistry: 6950 S. Holly Circle Suite #202, Centennial CO 80112

Phone: 303-770-2252 / **Fax:** 303-773-2151

E-Mail: office@southmetrodentistry.com

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

Information Requested:

__X__Copy of complete dental chart

__X__Copy of dental x-rays

Purpose or need for which in for is to be used:

_______Transfer of Records ________Second Opinion

AUTHORIZATION: *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it.*

______________________________ ______________________________

Patient Name (print) Person Authorized to Sign for Patient

______________________________ ______________________________

Signature Date

SOUTH METRO DENTISTRY
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What You Can Expect

Oct 2020

“Best dentist that I’ve EVER been to! So very professional. Whenever I have to visit, whether it is for an annual check-up and cleaning, or to have work done on my teeth, I feel that I am in good hands. Dr. Morse, and all the whole staff, are very caring, friendly and kind. I’ve had many dentists over the years, and I will NEVER go anywhere else. EVERYONE in the office seems to really love their job.” – P.O.

Dec 2020

“Brilliant, creative dentists that care deeply about their quality of work and their patients. Dr. Rivera beautifully solved my multi-faceted dental problems that the best dentists in LA and NY couldn’t handle. Also, I had fun during my time there. Superlative staff. I only wish I had found them sooner.” – K.E.

April 2021

“The South Metro team is so genuine, caring, professional, and highly skilled at dentistry. You will not find a better dental practice anywhere! Each staff member truly cares about not only your dental health, but your overall health and it shows in everything they do. From the minute you walk in the door, you will be treated with honesty, fairness, genuine kindness, and professionalism. You can’t go wrong with this practice, highly recommend!” – E.B.

May 2021

“Finding a great Dentist is hard. I’ve had my share of bad dentists in the past. Dr. Morse renewed my faith and I’ve been his patient for years now. I couldn’t recommend him and his staff more. They’re all amazing, kind, caring people and every visit has been great even through covid. I recently had veneers done to help the structure of my teeth and the process was painless and smooth. I can’t thank y’all enough.” – B.M.

September 2021

“Great dentist and the staff is amazing.” – T.T.

Oct 2021

“Knowledgeable, professional, kind, and caring staff are impressive. I have never had such a thorough analysis in my life. I wish I had used this practice years ago. Spotless office. I rarely write reviews but wanted to based off my experience.” – D.K.

Nov 2021

“Dr. Morse and team are so kind, patient, and professional. Every staff member in the office is friendly and respectful. Glad I found South Metro Family Dentistry!” – G.C.

SOUTH METRO DENTISTRY

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6950 S. Holly Circle Suite #202
Centennial, Colorado
80112