TIM OWENS DDS
DENTISTRY

New Patient Forms

Welcome!

Please take a moment to provide us with your information to help us ensure the quality of your care is excellent.

PATIENT INFORMATION:

Patient Name _____ Preferred Name _____

Date of Birth____/_____/_____ SS # _____-____-_____ Gender: ○ Male ○ Female

Status: ○ Married ○ Single ○ Child ○ Other Cell Phone_____ Alt. Phone_____

Address_____City_____ State_____Zip_____

E-mail _____

Please **unsubscribe me from the following appointment reminders? ○text to mobile# ○email ○call to home# **

INSURANCE INFORMATION:

Primary Policy Holder Information (if different from the patient above)

Name _____ Relation _____ DOB_____ SS # ____-____-_____

Employer _____ Insurance Company_____ Phone # _____

Insurance ID# _____ Group # _____ Group Name_____

Claims Address_____ City_____ State_____ Zip_____

GENERAL QUESTIONS:

How did you hear about our office? _____

Are you in dental pain right now? ○ Yes ○ No If yes, please explain_____

Do you experience any fear of the dentist? ○ Yes ○ No If yes, please explain_____

DENTAL HISTORY:

Have you ever been told you need to pre-medicate with antibiotic before treatment? ○ Yes ○ No

Have you had an orthopedic total joint replacement (hip, knee, etc.)? ○ Yes ○ No

Are you allergic to penicillin or other antibiotics? ○ Yes ○ No

Do your gums bleed when you brush? ○ Yes ○ No

Have you ever had orthodontic (braces) treatment? ○ Yes ○ No

Are your teeth sensitive to cold, hot, sweets or pressure? ○ Yes ○ No

Do you have earaches, ringing in ears or neck pains? ○ Yes ○ No

Have you had any periodontal (gum) treatments? ○ Yes ○ No

Do you wear removable dental appliances? ○ Yes ○ No

Have you ever had a serious problem associated with dental treatment? ○ Yes ○ No

If yes, please explain_____

Are you happy with the overall appearance and functionality of your teeth? ○ Yes ○ No

If no, please explain_____

HEALTH HISTORY:

Is your general health good? ○ Yes ○ No

Are you being treated by a physician for a chronic condition? ○ Yes ○ No

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If yes, please provide their name and phone _____

What was the date and purpose of your last visit with a physician? _____

Has there been a change in your health within the last three years? ○ Yes ○ No

Have you been hospitalized or had serious illness in the last three years? ○ Yes ○ No

If yes, why?_____

Do you have or have you had:

- ○ Heart disease
- ○ Heart murmur
- ○ Hepatitis, other liver disease
- ○ Herpes
- ○ High blood pressure
- ○ HIV
- ○ Jaw/Joint Surgery
- ○ Neuralgia
- ○ Osteoarthritis
- ○ Osteoporosis
- ○ Pacemaker
- ○ Chest pain (angina)
- ○ Difficulty swallowing
- ○ Dizziness/frequent headaches
- ○ Frequent vomiting, nausea
- ○ Persistent cough/coughing up blood
- ○ Swollen ankles
- ○ Anemia
- ○ Anxiety/Depression
- ○ Artificial joint
- ○ Asthma or lung disease
- ○ Chronic Fatigue
- ○ Diabetes
- ○ Fainting spells
- ○ Fibromyalgia
- ○ Sinus Problems
- ○ Skin disease
- ○ Stroke
- ○ Heart attack, heart defects
- ○ Arthritis
- ○ Seizures/Epilepsy
- ○ Prosthetic heart valve
- ○ Sleep Apnea
- ○ Psychiatric care
- ○ Tumors, cancer
- ○ Radiation treatment/Chemotherapy
- ○ Reaction to metal/jewelry
- ○ Rheumatic fever
- ○ Stomach problems/ulcers
- ○ Frequent urination
- ○ Difficulty urinating/blood in urine
- ○ Recent weight loss/fever/night sweats
- ○ Diarrhea, constipation, blood in stools
- ○ Bleeding problems, bruising easily
- ○ Dry mouth
- ○ Shortness of breath

Are you taking: ○ Recreational drugs ○ Alcohol ○ Medications (including OTC) ○ Tobacco in any form ○ Natural Remedies

For Women Only: Are you taking birth control? ○*Yes* ○*No*
Are you or could you be pregnant/nursing? ○*Yes* ○*No*

Please list all medications, supplements, or herbal preparations:

Please list all known allergies:

If you have any other disease/medical condition not mentioned on this form please explain:

To the best of my knowledge the preceding information is correct and complete:

Patient Signature _____ **Date** _____/_____/_____

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Consent for Services

In order to provide dental excellence to each of our guests, the following policies and terms have been established. For additional information, please refer to our Office Policies, which are also available online.

Appointment Changes: We are committed to providing an excellent dental experience for each of our guests and when you schedule an appointment, that time is specifically set aside for you. **We do not overbook to accommodate for patients not showing up for their appointments.** Last-minute cancellations, late arrivals, and failed appointments have a significant impact on our day and the service we can provide for each of our guests. **If you need to change an appointment, we ask you to give us 2 business days' notice.** If you cancel or change an appointment with less notice than this, neglect to arrive on time, or miss your appointment entirely, you may be asked to put down a $60 deposit for each hour of your next scheduled appointment.

Finances: Our mission is to deliver the finest dental care available today. Fine dentistry is truly an investment and our goal is to help you make this investment possible. For our uninsured patients, we offer the TO Savings Plan. To qualify for this savings plan, payment is due in full at the time of treatment and by cash or check. We are sensitive to the fact that some people may not be able to pay cash for their treatment; therefore, we offer some alternative payment programs for your convenience.

For those who enjoy dental insurance benefits, we will do our best to help estimate what your insurance plan will cover. We ask you to pay your estimated copay at the time that services are rendered. The amount of insurance coverage is an estimate only and may not reflect what your insurance carrier will actually pay. If a payment from your insurance company results in a credit balance or an unpaid balance, a refund or invoice will be sent to you. Please remember insurance is a contract benefit between you, your employer, and the insurance company. We will help you maximize your dental benefit, estimate copays, and will file your claims for you as a courtesy, but you, as the patient, are ultimately responsible for the complete cost of your dental treatment, regardless of insurance coverage.

Additional Charges: For any check that is returned, there will be a fee $25.00. For any unpaid balance, two paper bills will be sent, but if the balance remains unpaid, a re-billing charge of $10.00 may be added to your account for each additional bill that has to be sent. Any unpaid balance that remains on an accounts for over 30 days may also be charged up to a 5% monthly financing charge, unless previously written financial arrangements are satisfied. If your account is turned over to collections for failure to abide by the above terms listed, you will be responsible for all recovery costs including, but not limited to, collections fees, financing charges, attorney fees, court costs, and taxes.

I have read and understand my responsibility with regard to receiving excellent dental treatment and patient care. I acknowledge that I have received a copy of this office's Notice of Privacy Practices. If relevant, I hereby assign my payable insurance benefits to Tim Owens DDS, who is billing on my behalf, for application on my account. I authorize the release of any information necessary to process my insurance claims and understand that I am responsible to pay any amount that the insurance does not pay. I understand that if I do not pay my bill my account will be turned over to a collection agency and I will be responsible for any legal costs incurred in this process. By signing below I acknowledge that I have read the above conditions of treatment and payment and agree to their content in full.

Full Name (and relationship to patient, if relevant): _____

Signature _____ Date _____/_____/_____

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HIPAA Authorization Page & Statement of Receipt of Statement Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Tim Owens, DDS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Tim Owens, DDS reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

If you would like anyone else to have access to your patient file, information, etc. please indicate your preference below by marking "yes" or "no"

☐ **YES** ☐ **NO** **Spouse - name if not already on file: _____**
☐ **YES** ☐ **NO** **Parent(s) - name(s) if not already on file: _____**
☐ **YES** ☐ **NO** **Children - name(s) if not already on file: _____**
☐ **YES** ☐ **NO** **Other - please list name(s)_____**

Full Patient Name (and relationship to patient, if relevant) _____

Patient Signature_____ Date _____/_____/_____

Your HIPAA Representative at Owens DDS
Patient's personal HIPAA representative: Sarah Elliott, Practice Manager at Timothy M. Owens, DDS
Contact information for HIPAA representative: Phone: 970.377.2557 Email: office@owensdds.com
Mailing Address: Tim Owens DDS, 3506 Lochwood Dr, Fort Collins, CO 80525

OFFICE USE ONLY BELOW THIS LINE

If Acknowledgement Not Obtained:

Provided Prior to Treatment? ☐ YES ☐ NO
Date Statement Provided:_____
Reason for not obtaining patient signature

- ☐ **Needed more time to review Statement**
- ☐ **Wanted to consult another person before signing**
- ☐ **Physically unable to sign**
- ☐ **No reason offered**
- ☐ **Other:_____**