SMILE AURORA DENTAL
2900 S PEORIA ST. STE A, AURORA, CO 80014
Tel 303.368.3636 Fax 303.368.3631
smile@smileauroradental.com

Please email completed form to
smile@SmileAuroraDental.com

Patient Information

YOUR PERSONAL INFORMATION

Name: _____ _____ _____ _____
(Last) (First) (MI) (Preferred)

Birthdate: _____ **SSN:** _____ **Gender:** ☐ M ☐ F **Married:** ☐ Y ☐ N
MM/DD/YYYY

Wireless phone: _____ Wireless carrier: _____ **Work phone:** _____

Email: _____

Preferred contact method ☐ WirelessPh ☐ HomePh ☐ WorkPh ☐ Email

Preferred contact method for confirmations ☐ WirelessPh ☐ HomePh ☐ WorkPh ☐ Email

Student status, if dependent and over 19 years old (for insurance) ☐ Non student ☐ Fulltime ☐ Parttime

How did you hear about us? _____

(If someone referred you here, please write their name so we can thank them!)

ADDRESS AND HOME PHONE

☐ Check box if same for entire family

Address: _____

Address 2: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ **Relationship:** _____ **Phone number:** _____

Name: _____ **Relationship:** _____ **Phone number:** _____

INSURANCE POLICY 1 (Leave blank if it does not apply)

Your relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

☐ Check box if same for entire family

Subscriber Name: _____ **Subscriber ID#:** _____

Subscriber Birthday: _____ **Subscriber SSN:** _____

Insurance Company: _____ **Phone:** _____

Employer: _____ **Group Name:** _____ **Group#:** _____

Please present insurance card to receptionist.

INSURANCE POLICY 2 (Leave blank if it does not apply)

Your relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

☐ Check box if same for entire family

Subscriber Name: _____ **Subscriber ID#:** _____

Subscriber Birthday: _____ **Subscriber SSN:** _____

Insurance Company: _____ **Phone:** _____

Employer: _____ **Group Name:** _____ **Group#:** _____

Please present insurance card to receptionist.

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Medical History for New Patient

It is important that we know about your dental and medical history. These facts have a direct bearing on your dental health and is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Last name:_____ **First name:**_____ **Birthdate:**_____

Name and contact info of Medical Doctor:_____ **City/State:**_____
(leave blank if none)

Dental History

How long ago since you have seen a dentist?_____ Date if known:_____
(ex: 7 months ago, 2 years ago)

When was your last complete dental exam?_____ Date if known:_____

☐ Yes	☐ No	Are you **currently in pain**? (toothache, jaw pain, etc.)
		If yes, explain:_____
☐ Yes	☐ No	Are your **gums** tender, irritated, or easily bleed?
☐ Yes	☐ No	Are you aware of **GRINDING** or **CLENCHING** your teeth?
☐ Yes	☐ No	Are you **happy with the APPEARANCE** of your teeth/gum/smile?
		If no, what don't you like about your smile? _____
☐ Yes	☐ No	Would you like to discuss **ENHANCING the appearance** of your smile?
☐ Yes	☐ No	Would you like to discuss how to make your **teeth WHITE**?
☐ Yes	☐ No	Have you had any **periodontal (gum)** treatments?
☐ Yes	☐ No	Have you previously worn **braces** on your teeth (orthodontic treatment)?
☐ Yes	☐ No	Do you ***regularly*** use dental floss?

Do you have **any** of the following medical conditions? Check here if **none** apply ☐

	Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Epilepsy	☐	☐	Psychiatric care	☐	☐
Anaphylaxis	☐	☐	Fainting	☐	☐	Rapid weight gain/loss	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation treatment	☐	☐
Arthritis (Rheumatism)	☐	☐	Headaches	☐	☐	Respiratory disease	☐	☐
Artificial heart valves	☐	☐	Heart murmur	☐	☐	Rheumatic/scarlet fever	☐	☐
Artificial joint	☐	☐	Heart surgery/pacemaker	☐	☐	Shingles	☐	☐
Asthma	☐	☐	Other heart problems:	☐	☐	Shortness of breath	☐	☐
Atopic	☐	☐	_____			Skin rash	☐	☐
Back problems	☐	☐	Hemophilia	☐	☐	Spina Bifida	☐	☐
Blood disease	☐	☐	Herpes	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Hepatitis	☐	☐	Surgical implant	☐	☐
Chemotherapy	☐	☐	High blood pressure	☐	☐	Swelling of feet or ankles	☐	☐
Circulatory problems	☐	☐	Kidney disease	☐	☐	Thyroid disease	☐	☐
Cortisone treatments	☐	☐	Liver disease	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Nervous problems	☐	☐	Ulcer/Colitis	☐	☐

Are you ALLERGIC to any of the following?

- ☐ Anesthetic
- ☐ Aspirin
- ☐ Codeine
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa

Medical History

☐ Yes ☐ No **Are you taking any medication**?

If yes, list **all medication**:

_____
_____
_____
_____
_____
_____
_____
_____
_____

☐ Yes ☐ No Are you currently taking **blood thinners** (to prevent blood clots. Ex: aspirin, warfarin, Coumadin, Jantoven)?

☐ Yes ☐ No Do you use cigars/cigarettes, chewing tobacco, or recreational drugs?

If yes, circle above. How often:_____

☐ **Yes** ☐ **No** **Are there issues or conditions that you would like to discuss with the doctor in private?**

☐ Yes ☐ No *(Women ONLY)* Are you or could you be pregnant? If yes, what month:_____

☐ Yes ☐ No *(Women ONLY)* Are you currently nursing?

☐ Yes ☐ No *(Women ONLY)* Are you currently taking birth control pills?

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr. Kim, or any other member of her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Name:_____
(If patient is a minor, name of parent or legal guardian)

Date:_____
MM/DD/YYYY

Patient Signature:_____

When filling out the form electronically, please type your name here.
We will ask for your signature during your next visit.

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OFFICE POLICIES

Thank you for choosing to become a patient of Smile Aurora Dental.

Before we move forward in our relationship, we would like to make you aware of our office policies. We have these policies in place to better serve you and to be able to provide dental care in a pleasant, comfortable, mutually respectful environment.

1. **Late Policy**

   We do not see patient who are **more than 20 minutes late** for their appointment. If you have extenuating circumstances, please call our office no more than 10 minutes after your appointment time to let us know.

   This policy is to prevent our next patients, who arrive on time, from waiting to be seen.

2. **Cancellation**

   If you need to cancel an appointment, we require **48-hours business notice**. We understand emergencies happen. Please call us as we are willing to work with you; however, we require that you be respectful of our time that we reserve for your appointment and our other patients who may have wanted that appointment time. Should you need to cancel or change an appointment, you must call our office to do this (you may leave us voice-mail on our phone number).

   Our office provides **text message** or **email reminders**. Please let us know which you prefer or if you want both.

3. **Late/no-show Fee:**

   If you do not give 48-hours notice, are more than 20 minutes late, or simply do not show up to your scheduled appointment, there is a **$50 charge** for the first hour. If you are scheduled for more than one hour, then you will be charged an additional $25 for each half hour you were scheduled for. We understand that circumstances arise, and we are willing to work with your situation. Please call us should you need to cancel an appointment.

4. **Children:**

   We are happy to treat children! Please remember that an **adult must be present** in our dental office and accompany any children at all times in the reception area. We do not institute dental treatments on your child's first visit unless he/she is experiencing discomfort.

5. **Dental Insurance**

   We will submit claims to your insurance company for you at no charge and as a courtesy. We do our best to give accurate estimates on what the insurance will cover before we decide to move forward with your procedure. However, insurance companies can be unpredictable and they **do NOT give us a guarantee of what the full benefits or exclusions are on your policy.** Your Patient Benefits are conditional based on employment status, plan eligibility, provisions and exclusions, premium payment, and remaining benefits. Quoted benefits and our estimate costs are not guaranteed. **Ultimately, you are responsible for all payment not covered by your insurance company.**

   If you have concerns about payment and cost of treatment, we recommend that you contact your insurance company to learn more about your plan coverage.

6. **Payment:**

We expect you to be fully responsible for the timely payment of your account. **You are responsible for deductibles and estimated co-payments at the time of service.** If there is a balance left after insurance has paid your claim, we will mail a statement to your address. You may also choose to pay over the phone or use your credit card on file. The full balance is expected within 14 days. Unfortunately, for accounts that are over 45 days late, an interest charge of 1.5% will be added monthly. Accounts which are **over 90 days delinquent will be sent to collections**. The fees of collection agency may be based on a percentage at a maximum of 30% of the debt, and may include other costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

7. **Credit Card on File Policy:**

Smile Aurora Dental offers credit card on file option for all patients and family. This policy is designed to streamline the billing process in our office and eliminate the expenses related to handling overdue accounts. It will help us focus our time and energy on your dental care. Card information will be entered and securely stored in an **encrypted token** so that we DO NOT have full access to card information. Only the last four digits are visible to our staff.

We will not charge your credit card without consent and full explanation of the statement. If there are any balances remaining on your account, we will call you to make sure whether you would like to charge your credit card before we mail out any statements. Please note that the only circumstance where we may charge your credit card without notice is for "no show" fee in the event of late cancellation or missed appointments.

Consent

I have read, understand, and agree to all the above information titled **"Office Policies"** of Smile Aurora Dental regarding late policies, cancellation, rescheduling appointments, payments, insurances, and collections. I understand that I am expected to call the office to cancel or reschedule my appointment at least 48 hours prior to my appointment, and that there may be a fee for late cancellation or no-show.

Patient Name:_____
(If patient is a minor, name of parent or legal guardian)

Date:_____
MM/DD/YYYY

Patient Signature:_____
When filling out the form electronically, please type your name here.
We will ask for your signature during your next visit.

SMILE AURORA DENTAL

NOTICE OF PRIVACY PRACTICES CONSENT FORM

YOUR PRIVACY IS VERY IMPORTANT TO US!
PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Our Legal Duty and Summary of Notice

Smile Aurora Dental ("we," "our," "us"), like all other medical and dental practices, is required by applicable federal and state laws to maintain the privacy of your health information. We make it our priority to keep your personal information confidential, however there are certain situations where this sensitive information must be used or disclosed to other entities. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations.

Examples of when your information will be used or disclosed:

- When there is a need to involve another dentist or medical doctor.
- Verification of insurance plan/benefits through your insurance company or entity.
- Release of treatment records for insurance claims that we submit on your behalf.
- Business associates, such as billing and electronic claim services we have contract with.
- We may call, text, or email you regarding your appointment or post-procedure instructions.
- In an emergency, we may disclose your information to your family member or emergency contact.
- When required by law.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. The Notice also describes your rights to access and control your protected health information. Further, the Notice informs you of your rights to complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

We are also required to give you this notice about our privacy practices, 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 went into effect Jan 1, 2017 and will remain in effect until modified or replaced. 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 according to the means outlined in this notice.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read this office's Notice of Privacy Practices and acknowledge that I can receive a copy of it upon request. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities, and healthcare operations.

Patient Name: _____
(If patient is a minor, name of parent or legal guardian)

Date: _____
MM/DD/YYYY

Patient Signature: _____
When filling out the form electronically, please type your name here.

Save as PDF | Print Form | Submit using Email App | Reset entire form

Thank you for taking your time to complete this registration form. If you used a computer to fill out the form, the best way to send this information is to "**Save as PDF**" and email us the saved file as an attachment. *"Submit using Email App" button may not work properly if you do not have a default email application setup on your device.*