

# Smoky Hill Dental, PC

## Notice of Privacy Practices

**This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.**

At our office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of progress to your insurance company.

We may share your medical information with our business associates, such as a billing service. We may have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example we may send postcards or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You must sign a release form for the information.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us your written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for copies.

You have the right to request amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice. If you would like a copy, please ask the receptionist. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue S. W., Room 509f, Washington DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our privacy officer (see list on back for contact information.)

This notice goes into effect as of April 14, 2003.

Acknowledgement: I have received a copy of this office's Notice of Privacy Practices.

In order to prevent unauthorized access to our patient's vital information, we have established an identity theft program. All vital documents, both paper and electronic will be shredded prior to disposal. No credit card numbers will be kept on file. Checks will be kept in a safe place and any copies will be destroyed properly. Charts will be kept in a secure area with an alarm system to prevent theft. Patients will be notified if there is a breach in our identify theft program.

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

Signed: \_\_\_\_\_ Print Name: \_\_\_\_\_

If signing as a parent of guardian, please note the name of the patient:(s)

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Office Contact Information  
Smoky Hill Dental, P.C.  
18525 E. Smoky Hill Rd. #D  
Centennial, Co 80015  
Privacy Officer: Cindy S.

## DENTAL & MEDICAL HISTORY

Patient's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M \_\_\_ F \_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Married? \_\_\_\_\_ Single? \_\_\_\_\_ Divorced? \_\_\_\_\_ Minor? \_\_\_\_\_ Partnered for \_\_\_\_\_ years?  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ SS# \_\_\_\_\_  
Full Name of Spouse/Parent \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Spouse/Parent Employer \_\_\_\_\_ Occupation \_\_\_\_\_ SS# \_\_\_\_\_  
Whom may we thank for this referral? \_\_\_\_\_

**EMERGENCY INFORMATION** :( Name, Address & Telephone number of a Relative NOT living with you):  
\_\_\_\_\_

### DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insured's Employer \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Group # \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION

Insured's Name \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insured's Employer \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Group # \_\_\_\_\_

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

### Medical History:

Previous Dentist \_\_\_\_\_ Physician's Name \_\_\_\_\_ Phone number \_\_\_\_\_

Do you have any CURRENT HEALTH PROBLEMS? Yes / No If yes, what? \_\_\_\_\_

### List Current Medications:

List any Allergies you may have to Medications: \_\_\_\_\_

(Women) Are you pregnant? \_\_\_\_\_ Nursing? \_\_\_\_\_ Taking Birth Control Pill? \_\_\_\_\_

### Circle any of the following which you have had or have at present:

Anemia	Arthritis, Rheumatism	Artificial Heart Valve	Artificial Joints, Pins, Etc	Asthma
Back Problems	Bleeding Abnormally	Blood Disease	Chemical Dependency	Cancer
Chemotherapy	Circulatory Problems	Congenital Heart Lesions	Cortisone Treatments	Diabetes
Epilepsy	Fainting	Glaucoma	Sinus Problems	Headaches
Heart Murmur	Heart Problems	Hemophilia	Hepatitis	Skin Rash
Hernia Repair	High Blood Pressure	HIV/AIDS	Jaw Pain	Pacemaker
Kidney Disease	Liver Disease	Mitral Valve Prolapse	Radiation Treatment	Stroke
Respiratory Disease	Rheumatic Fever	Scarlet Fever	Shortness of Breath	Ulcer
Swelling Feet/Ankles	Thyroid Problems	Tobacco Habit	Other: _____	

Date: \_\_\_\_\_ Doctor Signature: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

**CONSENT:** The undersigned hereby authorize Doctor to take x-rays, study models, photographs, or any diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. **I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I assign all insurance benefits to the Doctor.**

Patient Signature (Parent or Child) \_\_\_\_\_ Date \_\_\_\_\_

## SMOKY HILL DENTAL OFFICE POLICY

We would like to make your visits as pleasant, comfortable and convenient as possible. The following will explain to you our procedures and policies, which have been established so that we may serve you as promptly and efficiently as possible.

### APPOINTMENTS

The doctors and staff at Smoky Hill Dental will make every effort to begin treatment at your appointed time; however, dental emergencies do occur frequently. When this happens, we ask for your understanding. If this causes problems with your schedule, please feel free to reschedule your appointment. If you find that you cannot keep your appointment, kindly give us at least 24 hours notice. (1 full business day) **A fee will be charged to any patient who fails to give 24 hours notice or fails to show for an appointment.** For safety reasons, we ask that only the patient be allowed in the operatory while work is being completed. Parents will be asked to come back for exams on children.

### INITIAL VISIT

Unless you have an emergency, your first appointment will be a thorough examination, including appropriate x-rays. A summary (**estimate**) of services to be rendered and the cost of the completed treatment will be given to you prior to the start of any further dental treatment.

### CHILDREN

We are happy to treat children of any age. We recommend that a child have his/her first dental examination between his/her third and fourth birthdays. We do not institute dental treatment on your child's first visit unless he/she is experiencing discomfort. We may also need to refer your child to a pediatric dentist. Children must be accompanied by an adult at all times while in the reception area. **Please accompany all children (up to age 18) for their initial dental visit, as your consent is needed before any treatment can begin.**

### FINANCIAL ARRANGEMENTS

**ALL EMERGENCIES ARE TO BE PAID FOR IN CASH AT THE TIME OF SERVICE IF NO INSURANCE COVERAGE.** All co-pays and other balances are due at the time of service. After your insurance company has processed our claim, if there is any balance due from you, such as deductible or coinsurance, we will send you a statement. Balance is due upon receipt of the statement. If payment cannot be made in full within 30 days, please contact our office for a possible payment arrangement. If payment arrangements are not made, you may be sent to a collection agency. I further agree to pay all finance charges, collection cost, attorney fees, and any other cost that may be incurred to enforce collection of any amount outstanding. Once the account has been sent to collections, we no longer have control of the account and can no longer discuss details of your account with you.

We will do our best to verify your insurance eligibility and an estimate of benefits at the time of service. However, a quotation of eligibility and benefits from your insurance company does not guarantee payment. **Please understand that financial responsibility for your account is yours, not your insurance company's.** Please provide us with any Insurance information or Insurance changes prior to any scheduled appointments. You may use your MasterCard or Visa for payment at the completion of each appointment. **A \$50.00 fee will be charged for returned checks.**

**I have read and understand these policies:**

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date