Patient Information

Date: _____

NAME: _____ **PREFERED NAME:** _____
Last First M

SOCIAL SECURITY: _____ ☐ Married ☐ Single ☐Minor ☐Male ☐Female

ADDRESS: _____
Street Apt # City State Zip

BIRTH DATE: _____ **NAME OF EMPLOYER:** _____
Month Day Year

TELEPHONE: _____
Home Work Cell Email

PERSON RESPONSIBLE- PLEASE CHECK ONE: ☐ Patient ☐Guardian ☐Spouse ☐Father ☐Mother

Insurance Information

PRIMARY INSURED	**SECONDARY INSURED**
Last First M	Last First M
Street City State Zip	Street City State Zip
Home Cell Email	Home Cell Email
Birth date Relationship to Patient	Birth date Relationship to Patient
Employer Dental Insurance Company	Employer Dental Insurance Company
SS # Subscriber # Group #	SS # Subscriber # Group #

Emergency Contact

Name: _____

Address: _____

City/State/Zip: _____

Telephone Number: _____

Have any family members been treated in this office?

☐ Yes _____ ☐ No

Who may we thank for referring you to our office?

_____

Authorization

I hereby authorize payment directly to Dr. Heather Harris' office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I herby authorize the Dr. Heather Harris' office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

_____ _____
Patient or Responsible Party Date

PATIENT NAME _____ **DATE** _____

Dental History **Please Circle**

Do you have a specific dental problem? Describe: _____	Yes	No
Do you have dental examinations on a routine basis? Last Visit _____	Yes	No
Do you think you have active decay or gum disease? _____	Yes	No
Do you brush and floss on a routine basis? Explain: _____	Yes	No
Do your gums ever bleed? Explain: _____	Yes	No
Do you like your smile? Why?: _____	Yes	No
Does food catch between your teeth? Any loose teeth? _____	Yes	No
Do you want to keep your remaining teeth? _____	Yes	No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____	Yes	No
Have your past experiences in a dental office always been positive? _____	Yes	No
Do you smoke or chew? Any sores or growths in your mouth? Explain: _____	Yes	No
Name of previous dentist (optional): _____	Yes	No
Date of last full mouth x-rays (16 small films or panoramic): _____	Yes	No

Medical History

Are you under a physician's care now? Why? _____	Yes	No
Have you ever been hospitalized or had a major operation? Explain: _____	Yes	No
Have you ever had a serious injury to your head or neck? Explain: _____	Yes	No
Are you taking any medications? If so, please fill out the back side of this form. _____	Yes	No
Are you on a special diet? Explain: _____	Yes	No
Are you allergic to any medications or substances? Please check box below: _____	Yes	No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Milk ☐ Other _____

*Women (Please Check) ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives _____

Do you have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.
* If yes to any of the starred conditions, please call prior to your appointment. Premedication or changes may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery*	☐	☐	Lung Disease	☐	☐	Hpoglycemia	☐	☐	Drug Addiction	☐	☐	Psychiatric Care	☐	☐
Heart Murmur or Defect	☐	☐	Breathing Problem	☐	☐	Heapatitis A	☐	☐	Alcoholism	☐	☐	Need Premedication?	☐	☐
Irregular Heart Beat	☐	☐	Shortness of Breath	☐	☐	Hepatitis B or C	☐	☐	Recent Weight Loss	☐	☐	Allergies (Medicines)	☐	☐
Angina/Chest Pain	☐	☐	Frequent Cough	☐	☐	Protease Inhibitor	☐	☐	Tattoos/Body Piercing	☐	☐	Fosamax/Actonel/Boniva	☐	☐
Heart Attack/Failure	☐	☐	Hay Fever	☐	☐	Night Sweats	☐	☐	Hives or Rash	☐	☐	Genital Herpes	☐	☐
Congenital Heart Disorder*	☐	☐	Blood Transfusion	☐	☐	Yellow Jaundice	☐	☐	Excessive Thirst	☐	☐	Ever taken fen-phen?	☐	☐
Mitral Valve Prolapse*	☐	☐	Leukemia	☐	☐	Kidney Problems	☐	☐	Alzheimer's Disease	☐	☐	Cochlear implants?	☐	☐
Scarlet Fever	☐	☐	Bloody Sputum	☐	☐	Renal Dialysis	☐	☐	Rheumatic Fever*	☐	☐	Nervousness	☐	☐
Emphysema	☐	☐	Thyroid Disease	☐	☐	Cold Sores	☐	☐	Sleep Apnea	☐	☐	Excessive Bleeding	☐	☐
Artificial Heart Valve*	☐	☐	Tuberculosis	☐	☐	Parathyroid Disease	☐	☐	Liver Disease	☐	☐	Allergies (Pollen/Dust)	☐	☐
Heart Pacemaker*	☐	☐	Cancer	☐	☐	Arthritis/Gout	☐	☐	Herpes	☐	☐	Frequent Diarrhea	☐	☐
Pulmonary Shunt*	☐	☐	X-Ray Tx (Radiation)	☐	☐	Rheumatism	☐	☐	Stroke	☐	☐	Zometa IV	☐	☐
High Blood Pressure	☐	☐	Chemotherapy	☐	☐	Pain in Jaw Joints	☐	☐	Convulsions	☐	☐	Asthma	☐	☐
Low Blood Pressure	☐	☐	Osteoporosis	☐	☐	Cortisone Medicine	☐	☐	Epilepsy or Seizures	☐	☐	Sinus Trouble	☐	☐
Bacterial Endocarditis*	☐	☐	Bisphosphonates	☐	☐	Artificial Joint*	☐	☐	Glaucoma	☐	☐	Fainting or Dizziness	☐	☐
Unexplained Fever	☐	☐	Osteonecrosis of Jaw	☐	☐	Sexually Trans. Disease	☐	☐	Diabetes	☐	☐	Aredia IV Reclast IV	☐	☐
Bruise Easily/Blood Disease	☐	☐	Coronary Stent*	☐	☐	AIDS	☐	☐	Tumors or Growths	☐	☐	Methemoglobinemia	☐	☐
Anemia	☐	☐	HIV Positive	☐	☐	Stomach/Int Disease	☐	☐	Ulcers	☐	☐	Hemophilia	☐	☐
Sickle Cell Disease	☐	☐												

Have you ever had any other serious illness not checked above? Explain _____	Yes	No
Do you wish to talk to the dentist privately about any problem? _____	Yes	No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

_____ _____

Patient Signature Date

Medical Updates

I have ready my Medical History dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions	Pateint's Signature	BP	Pulse	Reviewed By

GENERAL CONSENT

Thank you for choosing out office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. Drug or chemical reaction. Dental materials and medications may trigger allergic or sensitivity reactions.

2. Long-term numbness (Paresthesia). Local anesthetic or its administration, while almost always adequate to allow comfortable care, can result in transient or in rare instances permanent numbness.

3. Muscle or joint tenderness. Holding one's mouth open can result in muscle or jaw joint tenderness or in a predisposed patient precipitate a TMJ disorder.

4. Sensitivity in teeth or gums, infection, or bleeding.

5. Swallowing or inhaling small objects.

While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statement on this page.

_____ _____

Patient's Signature Date

_____ _____

Parent/Guardian Signature (if patient is a minor) Date

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/16/2013, and will remain in effect until we replace it.

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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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 at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;

- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request

if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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 or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services 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 us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Jessica Pflueger
Telephone: 303-393-0039

Heather K. Harris, DDS, PC

Dentistry on the Creek

FINANCIAL POLICY

In the case where you do have insurance coverage, we will file insurance for the portion of the fee that we estimate they will cover, and you will be required to pay the estimated balance due at the time of the appointment. Once payment from insurance has been received, if there is any balance still remaining, it will be billed to you. If the payment from insurance results in a credit balance, this will be refunded to you.

Absolutely no person in this office can guarantee that your dental insurance will pay anything at all or how much they will pay. Dental insurance will not give us any guarantee and therefore we cannot guarantee anything on their behalf. We are separate entities.

Financing Option: Our office currently works with Care Credit, which will provide financing to patients specifically for their dental treatment. This allows you to spread out the cost of your treatment over time with no interest or low interest charges, depending on which option you choose. This allows you to proceed with your treatment in a timely manner while making low monthly payments.

We strive to ensure you are informed of all of our policies and procedures, and to make all aspects of your experience with us as comfortable for you as possible. If you have any questions about our office policies, please ask to speak with our Office Manager, so that these can be addressed.

I have read and I understand the above Financial Policies and have been provided with the answers to any questions I have at this time.

_____ _____

Patient Signature **Date**

In the event that you need dental treatment, is there another person (e.g. spouse, parent, etc) who is involved in decisions regarding your healthcare and/or your financial decisions? Yes_____ No____

If yes, please give their name and relationship to you: _____

Heather K. Harris, DDS, PC

Dentistry on the Creek

DISCLOSURE AUTHORIZATION

Names of Family and/or Friends we may discuss your treatment/health with:

_____	Relationship:_____
_____	Relationship:_____
_____	Relationship:_____
_____	Relationship:_____
_____	Relationship:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Printed Name

_____
Signature

_____
Date

For Office Use Only

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

- ☐ Individual Refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

DR. HEATHER K HARRIS, DDS

3955 E Exposition Ave, Suite #402
Denver, CO 80209

Cancellation Policy

At Heather K. Harris, DDS, PC, we strive to render care in a timely and prompt manner. When a patient misses a scheduled appointment, or cancels an appointment with minimal notice, not only is that time lost, but it negatively impacts our ability to schedule other patients that require dental care. Heather K. Harris, DDS, PC has thus adopted the following Cancellation Policy. By signing below, you hereby acknowledge and agree to the following:

- Any patient that fails to show up for a scheduled appointment, cancels, or re-schedules appointment with less than **48 hours' notice (business days)**, will be charged a Cancellation Fee. ***Please note if your appointment is set for Monday we require notice no later than that previous Thursday 12:00 pm.***
- Cancellation Fees can range from $25.00 up to $200.00 depending on the length of the appointment and the specialty of the provider with whim it was scheduled. We can provide the exact amount of the Cancellation Fee at the time an appointment is scheduled.
- All outstanding Cancellation Fees must be paid in full prior to the scheduling of a patient's next appointment.
- Patients are solely responsible for the payment of Cancellation Fees, not insurance companies or the third-party payers.
- Any patient who, in a given 12-month period, misses three or more scheduled appointment, or cancels three or more scheduled appointment with less than 48 hours' notice, may be dismissed as a patient from Heather K. Harris, DDS, PC.

I have read and understand the above Heather K. Harris, DDS, PC Cancellation Policy and I agree to be bound by its terms.

_____
Patient Name

_____ _____
Patient/Guardian Signature Date

Please mark down below if you would like a copy of our policy to have for your records:

___ Yes, please. ____ No, thank you.