DAVID W. LARSEN, DMD
Family & General Dentistry

New Patient Information - Medical and Dental History Form

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name if applicable)

Address: _____
Street *City* *State* *Zip Code*

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Social Security #: _____ Birth Date: _____ E-mail: _____
(Strictly Confidential) (For office correspondence – Not shared with anyone)

Who may we thank for referring you to our practice? ☐ Yellow Pages ☐ Website (LarsenDental.com) ☐ Sign / Location

Another patient - Name: _____ (*So we may provide them a patient-referral reward*) ☐ Other _____

Emergency Contact: _____
Name *Phone Number* *Relationship*

Immediate Family members who are patients of this office: _____

Financially Responsible Party ☐ Check Here If Same As Patient Information Above (and leave this section blank)

Who is responsible for this account? _____ Relationship to Patient _____

Social Security #: _____ (Strictly Confidential) Birth Date: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Address: _____
Street *City* *State* *Zip Code*

Dental Insurance

Primary Insurance (if applicable) ☐ **Check Here If You Do Not Have Dental Insurance (and leave this section blank)**

Name of Employee: _____ Is employee a patient? ☐ Yes ☐ No
Last First MI

Employee's Birth Date: _____ Soc. Sec. #: _____ Group #: _____

Employee's Address: _____
Street City State Zip Code

Patient's relationship to employee: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Employer Name: _____ Insurance Plan Name _____

Secondary Insurance (if applicable)

Name of Employee: _____ Is employee a patient? ☐ Yes ☐ No
Last First MI

Employee's Birth Date: _____ Soc. Sec #: _____ Group #: _____

Employee's Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Employer Name: _____ Insurance Plan Name _____

Name: _____ **Date:** _____

Medical History - Patient or Guardian to Complete

Have you ever had or been diagnosed with any of the following? Please check those that apply:

- ☐ Allergies to medications or **Latex** _____
- ☐ Arthritis
- ☐ **Artificial Heart Valves**
- ☐ **Artificial Joints (i.e. hip or knee)**
- ☐ **Atrioventricular Fibrillation AFib**
- ☐ Asthma
- ☐ **Bleeding Tendencies**
- ☐ **Blood Thinning Medications**
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Convulsions/Seizures
- ☐ Growths/Tumors
- ☐ Head Injuries
- ☐ Healing Complications
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Hemophilia/Anemia/Blood Disorder
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pregnant – Currently
- ☐ Radiation Therapy or Treatment
- ☐ Reaction to Anesthetic
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Sinus Problems
- ☐ Steroid Therapy
- ☐ Stroke
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Other – Not Listed:_____ _____
- ☐ None of the Above

Yes No- Please Check Appropriate Box

- ☐ ☐ Have you had a surgery or have been admitted to a hospital in the past two years? Please explain: _____ _____
- ☐ ☐ Have you ever had an anaphylactic reaction? Please explain:_____
- ☐ ☐ Are you allergic to or have reacted adversely to Latex? Local Anesthetic? (please circle)
- ☐ ☐ Have you ever had prolonged or unusual bleeding after a surgery or dental appointment?
- ☐ ☐ Do you have a condition requiring you to take antibiotics before dental treatment such as having an (artificial joint i.e. knee or hip or heart conditions/surgeries)?
- ☐ ☐ Are you currently taking any blood thinning medications? Please List _____
- ☐ ☐ Are You Currently Taking Any Other Medications? Please List or Attach: _____ _____ _____
- ☐ ☐ Have you ever taken Bisphosphonate / Osteoporosis Medication (Fosemax, Aredia, Zometa, Actonel, Bonva, Didronel, Boneva, etc)?

Office Use – Medical History Review

Medical Alerts- A

- ☐ A-None
- ☐ A-AFib
- ☐ A-Allergy Latex
- ☐ A-Bisphosphonate
- ☐ A-Bleeding Hemophilia/Anemic
- ☐ A-Blood Pressure High
- ☐ A-Blood Thinning Medication
- ☐ A-Epi-Sensitive
- ☐ A-Heart Condition
- ☐ A-Other_____
- ☐ A-Pre-Med Artificial Joint
- ☐ A-Pre Med – Heart Condition
- ☐ A-Radiation Therapy

Medical History Notes

Dr. Larsen Review: _____ **Dentrix Updated** (Medical Conditions and Med Allergies) _____ **Scanned Complete** _____

Name: _____ **Date:** _____

Dental History - Patient or Guardian to Complete

Date of Last Dental Visit (approx.): _____ **Reason for today's visit:** _____

Yes No – Please Check

- ☐ ☐ Do you have teeth that are painful?
- ☐ ☐ Do you have teeth that are persistently sensitive to hot, cold, or sweets?
- ☐ ☐ Do you have teeth that hurt when you chew or teeth that you avoid chewing on?
- ☐ ☐ Do you have places between teeth that persistently trap food?
- ☐ ☐ Do you experience persistent dry mouth?
- ☐ ☐ Do you have clicking, popping, or pain in your jaw joints?
- ☐ ☐ Do you clench or grind your teeth that you are aware of?
- ☐ ☐ Have you ever had orthodontic treatment?
- ☐ ☐ Do your gums bleed while brushing or flossing?
- ☐ ☐ Have you ever been told you have Periodontal Disease (Gum Disease)?
- ☐ ☐ Do you use tobacco? Smoke or Smokeless? (Please circle)
- ☐ ☐ Did any of your family members (parents) lose their teeth at an early age?
- ☐ ☐ Do you have a history of Diabetes in your family that you are aware of?
- ☐ ☐ Do you have a history of Heart Disease in your family that you are aware of?
- ☐ ☐ Are you nervous about receiving dental treatment?
- ☐ ☐ Have you had any complications during or following dental treatment?
- ☐ ☐ Are you pleased with your smile?

How often do you brush your teeth? _____ How often do you floss?_____

Office Use - Dental History Review

Acknowledgement and Informed Consent -Patient or Guardian to Complete

Acknowledgement of Accurate Information

To the best of my knowledge, the questions on the two pages of this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes to my medical status or history. If I have any change in my medical status or medications I take, I will inform the Hygienist or Doctor at my next appointment.

Consent To Proceed

By signing this form, I freely give my consent to allow and authorize Dr. Larsen, his hygienists and or such associates or assistants as he may designate to perform the 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, including administration of any sedative (including nitrous oxide), analgesic, therapeutic, and or other pharmaceutical agent(s). The 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, to achieve these benefits, there are inherent risks associated with virtually any dental procedure including but not limited to: (1) Drug or chemical reactions. Dental materials and medications may trigger allergic or sensitivity reactions. (2) Long term numbness. Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in prolonged 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 jaw joint disorder. (4) Sensitivity in teeth or gums. (5) Damage to teeth, gum, or bone structures. (6) Bleeding, swelling, infection. (7) Swallowing or inhaling small objects. (8) Bruising, hematoma, cardiac stimulation, muscle soreness, irritations of soft tissues or other body parts.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with dental treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit and the benefit of my minor child or ward. While we follow procedural guidelines, which most often lead to a clinical success, just like in any other pursuit in health care, no procedural outcome can be guaranteed.

I have read the above conditions of treatment and agree to their content.

_____	_____	_____	_____
Signature of patient, parent, or guardian	**Printed Name**	**Relationship to Patient or Self**	**Date:**

Financial, Insurance, and Missed Appointment Policy

1. If You Are Covered By Insurance

As the patient receiving the benefit of treatment, you (or your "responsible party") are ultimately financially responsible for all dental services received, regardless of your insurance coverage. Insurance is a contract between you and your insurance company and our office is not a party to that contract. Our practice does not guarantee that your insurance company will pay for treatment you receive. As a courtesy, our office may assist with pre-authorizations and help to file your insurance claims. However, even though we are filing these claims in your behalf, we do not accept responsibility for the outcome of these transactions. The responsibility for full payment remains with you as the beneficiary of the services. If payment is not received from your insurance company within 60 days of the date of service, you will be expected to pay any outstanding balance in full.

Patients with insurance are expected to make a down payment (co-payment) at the time of service. This down payment amount is based on our experience and is merely an ESTIMATE of the portion that will not be covered by your insurance. After your insurance pays its portion of the claim amount, this down payment (co-payment), may be found to be insufficient to cover the remaining balance. You will then be responsible for payment of the balance. Similarly, any overpayment will be refunded to you.

2. If You Are Not Covered By Insurance

Patients without insurance are expected to make payment in full for all charges at the time of service unless prior financial arrangements have been made. Financial arrangements with our office must be made in advance of treatment.

3. Payment Options and Considerations

Payments may be made with VISA, MasterCard, Discover, CareCredit, debit card, cash or personal check. A $30.00 service charge is assessed on all checks returned unpaid by your bank. A service charge of 1.5% per month (18% annually) will be assessed for account balances that extend past 60 days. Charges for mailing statements may also apply.

Delinquent accounts (over 90-days due) will be referred to a collection agency at our discretion. If a collection referral becomes necessary, the undersigned aggress to pay all costs including reasonable attorney fees to effect payment. By signing this agreement you give permission to our office to telephone you at home or at work to discuss matters related to this form.

4. Insurance Authorization

With my signature below, I hereby authorize release of any relevant information necessary to process my claim to my insurance company. I also authorize any insurance benefits otherwise payable to me to be paid directly to David W. Larsen DMD LLC for services provided.

5. Deposit Policy

For some procedures, a deposit may be required to reserve the appointment time. In the event of a "missed appointment" without 48 hours notice, the deposit will be forfeited and will not be applied to any other treatment fee.

6. Missed Appointment Policy

Your scheduled appointment is a reservation. Our office reserves the appointment time just for you. If you need to re-schedule an appointment, we ask that you provide 48-hours notice.

A "missed appointment" is defined as not arriving for a scheduled appointment, cancelling an appointment with less than 48-hours notice, or arriving more than 10 minutes late. Patients who repeatedly miss appointments, increase the cost of providing healthcare to everyone and jeopardize their professional relationship with our office. Our missed appointment policy follows:

- After two "missed appointments" (in a 24-month period) in which 48 hours notice has not been given, you may be charged a $25 fee or the office may require you to pay a deposit before we reserve your next appointment. The deposit fee will be applied to any treatment rendered, or forfeited if your reserved appointment is "missed."
- Appointment Reminders: As a courtesy to our patients, our office will generally send confirmation post-cards or email notifications to patients two weeks prior to a re-occurring hygiene appointment. If the appointment time needs to be re-scheduled, we ask that call our office to make the scheduling change with at last 48 hours' notice.

7. Acknowledgement

This policy form represents an agreement between you as the patient and our office. It is intended to facilitate our ability to provide excellent service to you while minimizing administrative expenses. I acknowledge that I have read this agreement and agree with it.

_____ _____

Signature - Patient/ Responsible Party Date

DAVID W. LARSEN, DMD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice is available in the office. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, including any revisions of our Notice, at any time, by asking for one.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. 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 out treatment, payment activities and health care options.

Signature:_____ Date:_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

David W. Larsen D.M.D. / Larsen Dental

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 you this Notice about our privacy practice, our legal duties, and your rights concerning your health information. We must follow the privacy practice that are described in this Notice while it is in effect. This Notice takes effect April 15, 2003, 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. 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 and 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 at the end of this Notice.

USES AND DISCLOSURE OF YOUR HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment and healthcare operations. For example:

Another Healthcare Provider Who May Provide You Treatment: We may use or disclose your health information to a physician, another dental provider, or another healthcare provider who may provide treatment to you. This most often happens in the form of a referral to a dental specialist for consultation or treatment. This may also happen in the form of transferring your records to a new dental provider. Your dental radiographs are the most common requested health information requested by a subsequent provider. We may choose not to use a formal encryption or password-required platforms to transfer radiographs. This means theoretically, a third-party such as an internet, email, text, or phone provider theoretically could have access to your dental radiographs.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This most often happens in working with your dental insurance company to collect payment in your behalf. This may also happen in the form of working with an outside collection agency to collect an overdue balance.

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 of 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 your health information to a family member, friend or other person to the extent necessary to help with your healthcare, with payment for your healthcare, or with scheduling.

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 or 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 a determination using our profession judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment 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.

Education and Marketing Health-Related Services: We will not use your identifying health information for marketing communications without your written authorization. We may use radiographs, models, and isolated intraoral and extraoral pictures for

education, dental study groups, patient education, and marketing purposes to the extent that they do not specifically identify you and that your identity remains anonymous.

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

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders through such mediums as voicemail messages, postcards, letters, emails, or texts. For appointment reminders, we may choose not to use a formal encryption or password-required platforms to notify or remind you of upcoming appointments. This means a third-party such as an internet, email, text, or phone provider theoretically could have access to your appointment reminders. Additional information such as medications needed to be taken prior to the appointment may be included in these communications as well.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other that 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 the using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such a copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will 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 at the end of 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.

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

QUESTIONS AND COMPLAINTS

If you want more information about or 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 used 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.

Contact Officer: Dr. David Larsen
Telephone: 970-242-2717
Address: 1655 North 1st Street, Grand Junction, CO 81501