WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you.

As required by law, our office adheres to written policies and procedure to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you.

Patient Information

How would like us to address you? ____________________

Last Name_______________________ First Name_______________________

Address____

City_________________ State_______ Zip________

Home Phone___________________ Cell Phone_____________________

Email____ Soc. Sec. #: _____________

Mailing Address (if different from above) ____

____

Sex: M F Birthday_____________ ____Single ____ Married

Patient Employed by____

Business Address___________________________________ Business Phone______________

Emergency Contact _______________________________ Home Phone____________________

Cell phone ________________________ Relationship______________

How did you hear about us? ____

Which facial procedure(s) are you interested in?

____ Botox/Xeomin ____ Dermal Fillers _____ Threads _____ Kybella

Which area(s) do you want to address? ____

____

Have you ever had any facial aesthetic procedures done? Y N

If so, which procedures and how long ago? ____

____

Medical History

Physician's name____

Date of last visit ________________

Have you had any serious illnesses or operations in the last year? **Y N**

If yes, please explain:____

Do you use any tobacco products (smoking, chewing, snuff, etc.)? **Y N** If yes, how much:______
Do you use marijuana (recreational or medical)? **Y N** If yes, how much:________

Please mark (X) whether you have had or have any of the following:

- ☐ AIDS/HIV positive
- ☐ Anaphylaxis
- ☐ Anemia/Blood disease
- ☐ Angina
- ☐ Arthritis/Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Cancer/Chemotherapy
- ☐ Cardiovascular Disease
- ☐ Chemical Dependency
- ☐ Chest pain upon exertion
- ☐ Congenital Heart Disease
- ☐ Congestive Heart Failure
- ☐ Cortisone Treatments
- ☐ Diabetes Type: ____
- ☐ Dry Mouth
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Food allergies, specify ____________
- ☐ Gastrointestinal Disease
- ☐ Glaucoma
- ☐ Heart attack/surgery
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Hepatitis, type ____
- ☐ Hypertension
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Material allergies (LATEX, metal, etc)
- ☐ Neuro Disorder, specify ___________
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Reflux/heartburn
- ☐ Severe/rapid weight loss
- ☐ Stroke
- ☐ Thyroid Condition, specify_______
- ☐ Tuberculosis
- ☐ Ulcer/Colitis
- ☐ Other: ________________________

Women : Is there any chance you are pregnant?: Y N Are you nursing? Y N Taking birth control pills? Y N

What medications are you taking?
____
____

What allergies (drug & environmental) do you have?
____
____

Do you have any disease, condition, or problem not listed above that we should be aware of?
Please explain:____

Authorization

I certify I have read and understand the information given on this form is accurate. I understand this information will be used by the provider to help determine appropriate treatment. If there is any change in my medical status, I will inform the provider. I acknowledge my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my provider, or any member of his/her staff, responsible for any action they take or do not take because of error or omissions I may have made in the completion of this form.

I understand I am financially responsible for all charges.

Signature____________________________________ Date__________

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Durango Laser Dentistry
72 Suttle Street, Suite H
Durango, CO 81303
Phone: (970) 247-2677

With my consent, Dr. Miner may use and disclose protected health information about me to carry out treatment, payment, consultation, and healthcare operations. Please see Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, the office of Dr. Miner may:

_____ call my home _____ call my work _____ call my cell phone

_____ call or send appointment reminders _____ communicate via e-mail ____ communicate via text

_____ mail my home _____ consult supervising physician or health care providers to which I am referred

_____ I do authorize my clinical information/lab results to be transferable throughout the office and available or consultation with office staff.

By signing this form, I am consenting to the office of Dr. Miner to use and disclose my protected health information. I may revoke consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent Dr. Miner may decline to provide treatment to me.

Signature of Patient:____

Printed Name:____

Date:_______________________________________

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, ____have read and understand Dr. Miner's Notice of Privacy Practices.

____ ___________________________
Signature of Patient Date

OFFICE POLICIES

Thank you for choosing Durango Laser Dentistry. Our mission is providing to you, your family and friends the very best care. Please read the following guidelines carefully.

1. Scheduled appointments: Please plan to arrive 10 minutes in advance of your scheduled appointment. Our professional staff is trained to promptly assist you. If you are unable to keep a scheduled appointment, please call us at 247-2677 at least 48 hours prior to enable us to reschedule your appointment. **We reserve the right to charge a fee for late cancellations or missed appointments.** If a personal emergency arises please call Dr. Miner on his cell phone (number available on recording).
Please initial here you have read this paragraph: ________

2. Payment policy: Patient/guarantor agrees to pay all charges and fees on date of service. Please discuss special needs and payment options with our Office Manager in advance. A 15% APR finance charge may be applied for any unpaid balance over 90 days. Unpaid balances will incur an additional 50% of the unpaid balance added to the account if assigned to a collection agency. Additional costs including any collection agency fees, attorney's fee, court and related cost will also be added.

3. Returned checks are subject to a $25 charge.

4. Narcotic prescriptions may be placed on the Colorado State Drug Monitoring website.

I understand as the patient, guardian and/or parent; I am responsible for the entire balance of my account and for complying with terms of payment set forth.

By signing below, I accept the office policies as outlined above.

____
Signature

______________________________ ________________
Name Date

______________________________ ______________________________
Physical address Mailing Address