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 in maintaining your dental health.

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_____ Soc. Sec. #_____
Address_____
City_____ State_____ Zip_____ Home Phone_____
Cell Phone_____ Email_____
Mailing Address (if different from above) _____
Sex: M F Birthday_____ Single Married
Patient Employed by_____
Business Address_____BusinessPhone_____
Whom may we thank for referring you? _____
If yellow pages, Red book_____ or Yellow book_____
Notify in case of emergency _____Home Phone_____
Cell phone _____Business Phone_____ Relationship_____

Responsible Party/Insurance Subscriber

Insurance Company _____ Subscriber ID _____
Person responsible for account _____ Birth date _____
Relationship to Patient _____ S.S.# _____
Address (if different from patient) _____ City _____ St _____ Zip_____
Home phone _____ Cell phone _____

Are interested in **SEDATION**? Y N
Do you suffer from chronic headaches? Y N Migraines? Y N
Are you interested in aesthetic procedures (ie **Botox**, dermal fillers, Juvederm, etc.)? Y N
Are you interested in teeth straightening? Y N
Do you have a Facebook account? Y N Can we send you a friend request? Y N

Medical History

Physician's name_____
Date of last visit _____ Have you had any serious illnesses or operations? **Y N**
If yes, please explain:_____

When was your last dental cleaning? _____

Have you taken, currently taking, or scheduled to take either of the medications: Alendronate (Fosamax) or Risedronate (Actonel) for osteoporosis or Paget's Disease? **Y N**

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zomeda) for bone pain, hypocalcaemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? **Y N**

Dates treatment began;_____

Have you had a joint (hip, knee, elbow, finger) replacement? **Y N** If yes, when:_____
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:_____
Do you snore, have you snored, been told you snore? Y N Do you have a CPAP device? Y N

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
- ☐ Surgical Implant
- ☐ 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?

_____

_____

What dietary supplements are you taking (vitamins, herbal, etc.)? _____

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 dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I acknowledge my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, 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 authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

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

Dr. Miner
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

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

_____ 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

Local Anesthesia:
In connection with my dental work, local anesthetic may be used. Local anesthesia is commonly used during dental treatments and complications are rare but do, at times, occur. Risks that can be associated with local anesthesia include: dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or additional medical management and/or hospitalization. In addition, patients may experience restricted mouth opening during recovery, sometimes related to muscle soreness at the site of the injection requiring physical therapy. Local anesthesia may cause prolonged numbness that in some patients may result in injury from biting or chewing an area (lip, cheek or tongue) that has received the local anesthesia. Local anesthesia can cause injury to nerves that can result in pain, numbness, tingling, or other sensory disturbances to the chin, lip, cheek, gum, or tongue which may persist for several weeks, months, or, in rare cases, may be permanent. Local anesthesia is administered with a very fine needle. In rare instances these needles may break off or separate from the hub and become lodged in soft tissue.

By being seen at our office you consent to the use of local anesthetic, unless you specifically direct Dr. Miner not to use local anesthetic. Initial: _____

OFFICE POLICIES

Thank you for choosing Mason O. Miner, DDS, LLC. Our mission is providing to you, your family and friends the very best dental 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 24 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. Insurance: I understand my insurance is an agreement between my insurance company and myself. I also understand I am responsible for the balance of my dental account regardless of my insurance benefit. Co-payments on date of service are **estimates** only. I am responsible for claims not paid within 45 days of service.

5. 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

TO OUR PATIENTS WHO HAVE INSURANCE:

WE ARE HAPPY TO HELP YOU WITH YOUR INSURANCE BY ANSWERING QUESTIONS TO MAXIMIZE YOUR BENEFITS, WHAT YOUR CO-PAY MAY BE, ETC. HOWEVER, YOU MUST UNDERSTAND THE FOLLOWING:

1. IT IS **YOUR** INSURANCE – WE DO NOT HAVE ACCESS TO YOUR INSURANCE COMPANY TO KEEP TRACK OF BALANCES OR ANY CHANGES IN COVERAGE. **THESE ARE YOUR RESPONSIBILITY.**

2. YOUR INSURANCE IS A CONTRACT BETWEEN **YOU AND THE INSURANCE COMPANY.** WE ARE NOT A PARTY TO THIS CONTRACT IN ANY WAY AND, IN FACT, OTHER THAN TO VERIFY COVERAGE, YOUR INSURANCE COMPANY WILL NOT DISCUSS YOUR ACCOUNT WITH US. SO, IF YOU HAVE ANY QUESTIONS ABOUT THE AMOUNT OF YOUR COVERAGE OR YOUR REMAINING COVERAGE, YOU MUST CONTACT YOUR COMPANY, AS WE CANNOT.

3. NOT ALL SERVICES ARE COVERED BY YOUR INSURANCE. SOME INSURANCE COMPANIES ARBITRARILY SELECT CERTAIN SERVICES THEY WILL NOT COVER.

AGAIN, WE MUST EMPHASIZE THAT OUR RELATIONSHIP IS WITH YOU, THE PATIENT, NOT WITH YOUR INSURANCE COMPANY. WHILE WE WILL FILE YOUR INSURANCE FOR YOU AS A COURTESY, YOU NEED TO BE AWARE **ALL CHARGES ARE YOUR RESPONSIBILITY.** ANY QUESTIONS YOU MAY HAVE AS TO THE EXTENT OF COVERAGE, DENIAL OF BENEFITS, OR OTHER COVERAGE QUESTIONS MUST BE DIRECTED TO YOUR INSURANCE COMPANY, NOT OUR OFFICE.

_____

PATIENT INITIALS