ACQUAINTANCE FORM and HEALTH QUESTIONNAIRE

Patient Information

Last name ______________________________ Legal First Name _______________________ MI ____ Nickname _________________

Home Address____ City____________________________ State_______ Zip___________

Phone: Cell ______________________ Home ____________________ Work ________________ Birthdate_____/_____/_________

Occupation____ Your Employer ____

Email____ Social Security #_________________________

Spouse or Parent/Guardian Information

Last name _____________________________ Legal First Name ______________________ MI ____ Nickname __________________

Birthdate_____/_____/_________

Home Address____ City_________________________ State_______ Zip_____________

Phone: Cell _____________________________ Home _____________________________ Work _____________________________

ACQUAINTANCE FORM AND HEALTH QUESTIONNAIRE

Insurance Information

Who is responsible for payments? ____

Primary Dental Insurance

Name of dental insurance company: ____

Address where claims are to be mailed: ____

Subscriber (person insured): ____ Subscriber date of birth: ___________________

Social Security # / Alternate ID _________________________________ Group # ____

Secondary Dental Insurance

Name of dental insurance company: ____

Address where claims are to be mailed: ____

Subscriber (person insured): ____ Subscriber date of birth: ___________________

Social Security # / Alternate ID _________________________________ Group # ____

THIS FORM WILL BE PART OF YOUR OFFICE RECORD AND WILL BE HELD IN STRICT CONFIDENCE

IT IS IMPERATIVE THAT YOU COMPLETE THIS FORM BEFORE THE START OF YOUR APPOINTMENT. THIS INFORMATION ALLOWS US TO PROCESS YOUR CLAIM IN A TIMELY AND EFFICIENT MANNER. IF WE DO NOT HAVE THE CORRECT INFORMATION, YOU MAY INCUR LATE FEES AND/OR FINANCE CHARGES.

A STANDARD FEE FOR TREATMENT WILL BE APPLIED. PAYMENT IS DUE AT THE TIME OF THE APPOINTMENT. WHATEVER YOUR INSURANCE COMPANY COVERS MAY BE APPLIED TO FUTURE TREATMENT OR REIMBURSED TO YOU ONCE THE INSURANCE COMPANY HAS MADE THE PAYMENT.

Dental History

General Dentist ____ For How Long _____________ How many visits in the past 2 years? _______

Who referred you to this office? ____

What problem brings you to us? ____

When was your last cleaning? ____ Frequency? Every 3 / 4 / 6 months (circle one)

Please Circle "Yes" or "No"

Yes No Do you have any pain or soreness in your mouth?____

Yes No Have you had braces? When? ____

Yes No Have you been treated for gum disease? When? ____

Yes No Are your teeth sensitive to cold, hot or touch? Which teeth? ____

Yes No Do you have an unpleasant taste or odor in your mouth? ____

Yes No Does food catch between your teeth? Where? ____

Yes No Do you clench or grind your teeth? When? ____

Yes No Do you wear a night guard? ____

Yes No Do you have or have had any jaw joint problems? ____

Yes No Can you chew your food? What is the problem? ____

Yes No Do you want to keep your teeth? ____

Yes No Are you satisfied with the way your teeth and/or gums look? ____

Yes No Are you afraid of dental treatment? ____

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MEDICAL HISTORY

Physician ____________________ Address ____________________ Phone ____________________

Physician ____________________ Address ____________________ Phone ____________________

Date of last physical exam ____________________ Height ____________________ Weight ____________________ lbs

Please Circle "Yes" or "No" for the following questions:

Yes No Are you in good health?

Yes No Do you have any **current medical problems?** Please describe: ____________________

Yes No Do you have or have you ever had any of the following? (please circle)

Heart Disease	Hepatitis	Cancer or Tumor	Thyroid Disease
Heart Murmur	Tuberculosis	Radiation Treatment	Diabetes
Clogged Arteries	Sexually Transmitted Disease	Leukemia or Anemia	Liver or Kidney Disease
Stroke	Seizures	Arthritis	Asthma or Emphysema
High Blood Pressure	Psychiatric Treatment	Joint Replacement	Gastro-Intestinal Disease

Yes No Have you ever been **hospitalized** and/or had **surgery** (if YES, please list most recent)

When____________________ Why ____________________ When____________________ Why ____________________

When____________________ Why ____________________ When____________________ Why ____________________

Yes No Are you taking any **drugs, medications** or **pills**? Please list:

Taking ____________________ For ____________________ Taking ____________________ For ____________________

Taking ____________________ For ____________________ Taking ____________________ For ____________________

Taking ____________________ For ____________________ Taking ____________________ For ____________________

Yes No Are you **allergic** or have you reacted adversely to: (if YES, please circle)

Penicillin	Novocaine	Codeine	Aspirin
Mycin Antibiotics	Other Antibiotics	Local Anesthetics	

Other drugs, medications or pills (please list) ____________________

Yes No Do you **smoke**? How many packs a day? ____________________ For how many years? ____________________

Yes No Do you consume more than one **alcoholic drink** per day? How many? __________

Yes No Do you have **excess stress** in your life? For how long? ____________________

Yes No Do you have any **problem, disease** or **condition** not listed above? (if YES, explain)

____

____

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

For Women Only

Yes No Are you pregnant? Do you think you might be pregnant? Expected delivery date: ____________________

Yes No Do you have a history of miscarriages? ____________________

Yes No Have you reached menopause? ____________________

ACQUAINTANCE FORM AND HEALTH QUESTIONNAIRE

HIPAA PRIVACY AUTHORIZATION FORM

I, ____________________________________ have received a copy "Notice of Privacy Policies" from Shimoda & Boyesen Periodontics P.C.

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability & Accountability Act, 45 C.F.R Parts 160 & 164)

Authorization: I authorize Shimoda & Boyesen Periodontics, P.C. to use and disclose the protected dental information described below to _________________________________ *(referring and referred dentists, and insurance companies, if applicable.)*

Effective Period: This authorization for release of information covers (circle one):

a. The period of dental care from ____________________ to ____________________

b. All past, present and future periods

Extend of Authorization: (initial one)

a. _____ I authorize the release of my complete dental record.

b. _____ I authorize the release of my complete dental record with the exception of the following:

(Please specify): ____

The dental information may be used by the person I authorize to receive this information for dental treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effective until __________________________ (date or event), at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writhing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative: ____

Printed name of patient, or personal representative and his/her relationship to patient:

____ **Date:** __________________________

DENTAL RECORDS RELEASE FORM

Patient Name: ____

Date of Birth: ______________

Phone number: __________________________

Previous Dentist or Practice Name: ____

Street Address: ____

City / State / Zip: ____

Phone Number: ____

Please forward to **Shimoda & Boyesen Periodontics, P. C.** any of the following information that you have:

- X-Rays
- Probing Depth chart
- Charting
- Photographs

I hearby give you permission to release any and all of my dental records to Dr. Shimoda or Dr. Boyesen.

Patient Signature: __________________________________ **Date:** ________________

If records are digital, please email to:	**office@shimodaboyesenperio.com**
If mailed, please send to:	**Shimoda & Boyesen Periodontics, P.C.** **7761 Shaffer Parkway, Suite 240** **Littleton, CO 80127**
If faxed, please send to:	**303-979-2038**

FINANCIAL POLICY FOR PERIODONTAL & IMPLANT TREATMENT

The following financial information is provided for our patients. Our policy is to provide you with an understanding of the cost of treatment, your financial responsibility, options and dental insurance information.

For patients with dental insurance, a pre-determination or estimate of payment can be filed with your dental insurance company upon your request. And estimate of dental benefits available will take approximately 6-8 weeks for processing, pending any additional information needed. PLEASE keep in mind that this is only an estimate and the final cost to you may differ from the estimate. Our office will notify you once the estimate is received. Scheduling your treatment does not depend on the pre-determination of benefits.

METHODS OF PAYMENT

We accept all major credit cards, cash or check. We also accept Care Credit and will provide information regarding this payment option.

Dr. Boyesen is a network provider for the following insurance companies:

- Delta Dental Premier
- Delta Dental PPO
- MetLife
- Cigna

Our office does accept all insurance carriers. If you have benefits with a non-network carrier, your benefits may be reduced. Your co-payment (determined by your insurance company) is due at the time of treatment.

Our billing is done by **FIRST PACIFIC CORPORATION**. This is not a collection agency. You have 90 days in order to pay your bill in full before you are charged finance charges and late fees.

YOU ARE RESPONSIBLE FOR THE FULL AMOUNT AND/OR BALANCE DUE ON YOUR ACCOUNT. IF YOUR INSURANCE COMPANY HAS NOT PAID WITHIN THE ALLOTTED TIME, YOU ARE RESPONSIBLE FOR THE PAYMENT.

We encourage you to ask questions about our financial policies and your treatment options. We are confident and can assure you that we will provide the highest quality of care in all areas of your dental treatment. By signing below, you signify that you understand your financial obligations. If for any reason the account is turned over to a collection agency for non-payment, you agree to pay the cost of collection and/or attorney fees.

Patient Signature: ____ **Date:** ___________________

TRUTH IN LENDING
EXPLANATION OF INTEREST RATES, INTEREST CHARGES AND FEES

INTEREST RATES AND INTEREST CHARGES	
Annual Percentage Rate (APR) for Purchases	**15.00%**
Paying Interest	A finance charge is imposed on those charges not paid in full within 30/60/90/120 days (as shown on the front of your billing statement) of the date you were first billed for the charges. The balance on which any finance charge is computed is determined by totaling the charges not paid within the time period shown on the front of your billing statement and then by multiplying the balance by the periodic rate shown.
Minimum Interest Charge	**If you are charged interest, the charge will be no less than $1.00**

FEES	
Late Charge	**$1.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of $5.00**
Non-Sufficient Funds (NSF) Fee	**$25.00 per payment**

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064, but doing so will not preserve your rights. In your letter, please include the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain why you believe there is an error. If you need more information, describe the item you are not sure about.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.
- After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.
- If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.
- If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill and we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report you to that it has been settled.
- If we don't follow these rules, we can't collect the first $50.00 of the questioned amount even if your bill was correct.
- Your continued use of this account constitutes your acceptance of the above stated conditions.

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I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any insurance claims.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Shimoda & Boyesen Periodontics, P.C.
Dental Entity Name

______________________________ __________________
Signature Date

____
Printed Name

A photocopy of this document may act as an original Form 05304CO (7-1-17)