Longmont Complete Dentistry
Family Owned & Operated Since 1995

Daniel J Maurer DDS James A Maurer DDS

Patient Information:

Name: _____ Nickname: _____ Date: _____ M/F

Address: _____ Email Address: _____

City/State/Zip: _____ Preferred Phone: _____

SSN: _____ DOB: _____ Secondary Phone: _____

Previous Dental Office: _____ Preferred method : Email Text Phone Call

Do you have recent x-rays? (within past 12 months) EMERGENCY CONTACT: _____

Yes NO Contact # : _____ Relation: _____

Spouse or Parent (Primary Contact- If yourself skip this section)

Name: _____ Date of Birth: _____

Employer: _____ Preferred Phone #: _____

Occupation: _____ Preferred Email: _____

Dental Insurance Information:

Do you have dental Insurance? YES NO (If yes fill out below. If no skip to the next section.)

Primary Insurance		Secondary Insurance
Subscriber Name: _____		Subscriber Name: _____
Subscriber ID: _____		Subscriber ID: _____
Subscriber Date of Birth: _____		Subscriber Date of Birth: _____
Relationship to Subscriber: _____		Relationship to Subscriber: _____
Employer Name: _____		Employer Name: _____
Insurance Company: _____		Insurance Company: _____
Insurance Phone Number: _____		Insurance Phone Number: _____
Group Number: _____		Group Number: _____

Financial Responsibility and insurance information release:

I understand I am financially responsible for all charges whether or not I have insurance.

I, the undersigned, have insurance coverage and assign directly to Dr. Dan Maurer and Dr. Jim Maurer all dental benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Signed: _____ Date: _____

Medical History:

Patient Name: _____ Date of Birth: _____ Age: _____ E-mail Address: _____

Name of family Physician: _____ Telephone #: (___) _____
FIRST NAME LAST NAME

Physician Address: _____

Do you have, or have you had, any of the following? (Please Circle)

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Artificial heart valve
- ☐ Stroke
- ☐ Anticoagulant or Blood thinner
- ☐ Blood disease or Bleeding disorder
- ☐ Anemia (Current/Chronic)
- ☐ HIV or AIDS
- ☐ Diabetes A1C%____
- ☐ Stomach disease Ulcers or Reflux
- ☐ Lung disease
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Liver disease or Hepatitis (Type___)
- ☐ Kidney Disease
- ☐ Thyroid disease
- ☐ Skin disease
- ☐ Hysterectomy
- ☐ Head injury or Brain injury
- ☐ Facial or Oral trauma
- ☐ Seizures or Epilepsy
- ☐ Fainting
- ☐ Bone disease or osteoporosis
- ☐ Arthritis
- ☐ Joint Replacement
- ☐ Mental Health Therapy
- ☐ Tumor or Cancer history
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Allergies (Seasonal or Foods)
- ☐ Latex allergy or sensitivity
- ☐ Sinus Problems
- ☐ Canker or Cold sores

Do you use alcohol? ☐ Yes ☐ No # Drinks/Week: ____ Do you use tobacco (or marijuana)? ☐ Yes ☐ No Amount/Day: ____ x # Years: ____

☐ YES ☐ NO **Do you have any disease, condition, or problem not listed above? (If YES, list:)**

_____

☐ YES ☐ NO Have you ever been hospitalized and/or had surgery? (If yes, please list most recent:)

When: _____ Why: _____

When: _____ Why: _____

☐ YES ☐ NO Are you under the care of a physician now? Explain:

_____

☐ YES ☐ NO Are you taking medication, drugs, pills, vitamins or herbal supplements (if YES, list:)

_____

☐ YES ☐ NO Are you allergic or sensitive to aspirin, penicillin, or any other drugs or medicine? Explain:

_____

☐ YES ☐ NO Have you ever been treated for cancer with an I.V. drug like Zometa or Aredia?

☐ YES ☐ NO Have you ever taken a bisphosphonate medication for osteoporosis, such as Fosomax? If so, how long? ____ yrs ____ months

☐ YES ☐ NO If female, are you pregnant now? Delivery Date: _____ Are you nursing? ☐ Yes ☐ No

☐ YES ☐ NO If female, are you Post Menopause?

☐ YES ☐ NO Have you been out of the United States in the past 6 months? Where? _____

I consent to treatment if necessary or desired of the patient first named above, for diagnosis of dental disease, deformity, or treatment of dental emergency. In case of dental emergency, I consent to treatment, as deemed necessary by the doctor, understanding the procedures will be explained in advance. I understand it is solely my responsibility to report any changes in the above information to this office. I consent to my x-rays and dental records being sent to dental specialists and insurance claim offices or past dentists sending x-rays and dental records to Dr. Maurer.

Signed: _____ Date: _____

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.
The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment.

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

Please note: **Payment is due at the time service is provided.** **Our office accepts cash, personal checks, major credit cards and CareCredit.**

Payment Plans are available in some situations with a down payment and monthly service charge.
Additional fees will be applied for returned checks.

Accounts over 30 days from the date of service are subject to a billing statement fee of $5.00 and may also be charged interest per each additional billing statement.

All charges incurred are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a part to that contract.

As a courtesy to you, we will process your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a **guarantee** that your insurance will pay exactly as **estimated**. Insurance coverage is subject to limitations, exclusions, waiting periods, frequencies, age restrictions, deductibles and maximums which are your responsibility. While we gather
this information during the verification process and our computer system is designed to calculate your maximum and deductible, your
insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as
accurate as possible, but your estimated insurance benefit may different due to un-foreseen reasons related to your specific plan.

I agree to be financially responsible for all charges, services and materials not paid by my dental plan or covered by my plan if applicable. To the extent permitted by law, I consent to the dental office's use and disclosure of my protected health information to carry out payment activities in connection with the insurance claim. I hereby authorize and direct payment of the dental benefits, otherwise payable to me, directly to **Longmont Complete Dentistry**. *In the event my account is past due and sent to collection, I agree to pay for all fees associated with the account collection – usually 25% of the total outstanding account balance – court costs, and attorney fees.*

Signature _____ Date _____

Print _____ Date _____

Office Witness Signature _____ Date _____

Longmont Complete Dentistry

ACKNOWLEDGEMENT OF RECEIPT
OF
PRIVACY PRACTICES

I, _____, have received a copy of Longmont Complete Dentistry's Notice of Privacy Practices.

The following persons(s) are allowed access to my dental information, including my financial/account information:

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

Print Name: _____

Signature: _____ Date: _____

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)

_____

_____

_____

Longmont Complete Dentistry

WELCOME!!!!

The questions below are so that we can understand a little more about you and how you want your dental experience to go!

Name:_____ Date:_____

1. How did you hear about us? _____
2. When was your last dental cleaning and exam? _____
3. Are you ever nervous during dental visits? Yes_____ No_____
4. Do your gums bleed when you brush? Yes_____ No_____
5. Do you snore, ever wake from sleep gasping for breath, or has your partner ever told you that you stop breathing when you sleep? Yes_____ No_____
6. Are you interested in changing your teeth? Yes_____ No_____
7. If so, what would you like to explore changing?
   - Whiter Teeth _____
   - Straighter Teeth _____
   - Replace Missing Teeth _____
   - Fix Gaps _____
   - Misshapen Teeth _____
   - Overall just want a healthy mouth _____
8. When discussing your oral health, how would you like your information?

   Big Picture_____ Some Detail_____ Tell me everything_____

NOTICE OF PRIVACY PRACTICES

Longmont Complete Dentistry
2211 Mountain View Avenue
Longmont, CO 80501

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 practices, our legal duties, and your right s concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2017 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 or 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 the Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

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 or 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 authorizations to 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 revocations 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 or with payment for your healthcare, but only if you agree that we may do so.

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 disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional 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 of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
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 authorize 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 (such as voicemail messages, postcards, or letters).

Patient Rights
Access: You have the right to or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than 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 using the contact information listed at the end of this Notice. We will charges you a reasonable cost based fee for expenses such as 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 $1.00 for each page, $25.00 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 7 years, but not before April 1, 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.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our policy 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 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.