Kokopelli Family & Cosmetic Dentistry

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Welcome to our Family!

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* (Last) _____* (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____* (Address 1) _____ (Address 2)

_____* (City) _____* (State) _____-____* (Zip Code)

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Responsible Party Information:

This only needs to be completed if the insurance subscriber is someone other than the patient, or your are the parent/guardian of the patient.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance Company Phone Number:

Insurance Authorization:

☐ * **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

What is your immediate concern?

Previous Dentist Name and Phone Number:

Date of most recent dental exam and dental x-rays:

Is there anything about the appearance of your smile that you would like to change?

Check all that apply:

- [ ] Had complications from past dental treatment
- [ ] Had trouble getting numb
- [ ] Had any reactions to local anesthetic
- [ ] Had/have braces, orthodontic treatment
- [ ] You experience dry mouth
- [ ] Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- [ ] Food gets trapped between any teeth
- [ ] Have you ever whitened or bleached your teeth
- [ ] Have you experienced popping and/or clicking of your jaw joint
- [ ] You have difficulty chewing
- [ ] You clench or grind your teeth
- [ ] You wear or have worn a bite appliance or Night Guard?
- [ ] Gums bleed when brushing or flossing
- [ ] Treated for gum disease or were told you have lost bone around your teeth
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury)
- [ ] Experienced a burning sensation in your mouth
- [ ] You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

Appointment Cancellation and "no-show" Policy

Along with high quality dental work, our patients' comfort and convenience is a top priority for us at Kokopelli Family and Cosmetic dentistry. These values allow us to see patients on convenient hours such as late evenings and Saturdays. We call our patients a few days in advance to confirm their appointments, and any last minute cancellations inhibit us from reaching out to other patients, thus preventing us from taking care of them in time.

Week day appointments: We ask that you confirm your weekday appointments with us two business days in advance. Any last minute (less than 48 hrs on business days) cancellations and "no-show" will lead to a $50 charge.

Weekend/Saturday appointments: Saturday appointments not confirmed or cancelled under Two business days (less than 48 hrs on business days) before the appointment will be deemed "last minute". Any last minute cancellations and "no-shows" for a Saturday appointments shall lead to a $75 charge. Further more, patients will no longer be allowed to have another Saturday appointment.

We hope you understand our motivation behind discouraging cancellations and we appreciate your cooperation.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Appointment Cancellation Policy.**

Oral Cancer Screening Consent Form

Our practice continuously seeks advances to ensure that we are providing the optimum level of care to our patients. We are concerned about oral cancer and offer to screen every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause and both the occurrence and mortality rate of oral cancer continues to rise. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major contributing risk factors, however, more than 25% of oral cancer victims have no such lifestyle risk factors.

Oral cancer risk by patient profile is as follows:
Increase risk: Patients aging 18-39, sexually active patients 16-18 yrs/HPV.
High risk patients: Aging 40 and older, tobacco users.
Highest risk patients: Aging 40 and older, tobacco and or or alcohol use, previous history of oral cancer.

We have recently Incorporated VELscope in our oral screening standard of care. We find that using VELscope along with the standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. VELscope is similar to proven early detection procedures for other cancers such as mammography, PAP smear and PSA. VELscope is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of precancerous tissue can minimize or

eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The VELscope exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association (ADA). However, this exam might not be covered by your insurance. The fee for this examination is $50.

I authorize the clinician to perform the VELscope exam along with standard oral cancer examination. I accept financial responsibility for this enhanced examination.
*****

◯ Yes ◯ No

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Name and Relationship to Patient:

_____

_____

☐ *** By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Response Date: _____