Please fill out the following information so we can treat you safely and knowledgeably. This is a legal document, so it must be completed in ink. This information is confidential and we protect your information according to HIPAA.

NEW PATIENT INFORMATION

Name: _____
First Last Middle Preferred

Birth Date: _____ **SSN:** _____ **Gender: M F**

Address: _____
Mailing Address City State Zip

Home Phone: (___) _____ **Work Phone:** (___) _____

Cell Phone: (___) _____ **Are TEXTS accepted: YES NO**

Email: _____

What is the best way to contact you? (Please circle one)
Home phone Cell Phone Work Phone Email

Can we confirm your appointments through? (Please circle one)
Text Email Phone

DENTAL INFORMATION

How long has it been since you last dental visit? _____

What is the primary reason for your visit today? _____

What should we know about your previous dental treatment? _____

Have you ever had periodontal therapy (Deep cleaning, perio maintenance, gum surgery)? **YES NO**

Do you have problems with the following? If yes, when?	**YES**	**NO**
Pain in any teeth? (Cold, hot, sweets, etc) ……	☐	☐
Broken fillings? ……..	☐	☐
Sensitivity to biting? ……..	☐	☐
Bleeding when you brush or floss? …….	☐	☐
Clicking, popping or aching in your jaw? ……...	☐	☐
Grinding and clenching teeth? ……	☐	☐
Interest in whitening or changing the appearance of your teeth? ……...	☐	☐

MEDICAL INFORMATION

	YES	**NO**
Are you now under the care of a physician?	☐	☐
Physician Name: _____		
Physician Phone Number: _____		
Have there been any changes in your general health in the last year?	☐	☐
Please explain: _____		
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐

MEDICAL INFORMATION

Are you taking any prescription or over the counter medications? ……..... ☐ ☐

Please list all medications/supplements (include vitamins, herbal preparations and/or diet supplements):

_____

_____

_____

Are you taking (now or previous) the following medications (Bisphosphonates)?	**YES**	**NO**
Alendronate (Fosamax©)……	☐	☐
Risedronate (Actonel©)……..	☐	☐
Ibandronate Sodium (Boniva©)……..	☐	☐
Pamidronate Disodium (Aredia©)…….……	☐	☐
Zoledronic Acid (Zometa©, Aclasta©, Reclast©)…….…..…..	☐	☐
Do you use controlled substances (drugs/marijuana)?	☐	☐
Do you use tobacco (smoking, snuff, chew)?	☐	☐
Do you drink alcoholic beverages? ……..	☐	☐

ALLERGIES: Are you allergic to any of the following. Please indicate type of reaction:

Local anesthetics _____	☐	☐
Aspirin _____	☐	☐
Penicillin or other antibiotics _____	☐	☐
Sulfa drugs _____	☐	☐
Codeine or other narcotics _____	☐	☐
Latex _____	☐	☐
Other _____	☐	☐

PREMEDICATION: Please indicate if you have had the following disease or problem:

Has a physician/dentist ever recommended an antibiotics before dental treatment?	☐	☐
Have you had an orthopedic total joint replacement?	☐	☐
If yes, when? _____ Which Joint?_____		
Artificial (prosthetic) heart valve? ……..…	☐	☐
Previous infective endocarditis? …….	☐	☐
Damaged valves in transplanted heart? ……..	☐	☐
Unrepaired, cyanotic Congenital heart disease (CHD)? ……..	☐	☐
Repaired Congenital heart disease (CHD) in last 6 months? ……..	☐	☐
Repaired Congenital heart disease (CHD) with residual defects? ……..	☐	☐

WOMEN ONLY:

Are you pregnant? ……..	☐	☐
Are you taking birth control pills or hormonal replacement? ……	☐	☐
Are you nursing? ……	☐	☐

Please indicate if you have/have had any of the following diseases or problems:	**YES**	**NO**
Cardiovascular disease Please specify:	☐	☐
Angina	☐	☐
Congestive heart failure	☐	☐
Heart attack	☐	☐
High blood pressure	☐	☐
Pacemaker	☐	☐
Sleep Apnea – If yes, is a CPAP used? YES NO	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Blood Transfusion	☐	☐
Hemophelia	☐	☐
HIV or AIDS infection	☐	☐
Arthritis (including Rheumatoid)	☐	☐
Autoimmune disease	☐	☐
Systemic lupus erythematosus	☐	☐
Asthma	☐	☐
COPD (Bronchitis/Emphysema)	☐	☐
Tuberculosis	☐	☐
Cancer/Chemotherapy/Radiation therapy	☐	☐
Diabetes	☐	☐
Reflux or persistent heartburn	☐	☐
Thyroid problems	☐	☐
Stroke	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy or Seizures	☐	☐
Mental health disorders (including depression)	☐	☐
Kidney problems	☐	☐
Osteoporosis	☐	☐
Persistent swollen glands in the neck	☐	☐
Severe headaches/migraines	☐	☐
Other Please specify:	☐	☐

I certify that I have read and understand the above information. I have answered the above questions correctly and to the best of my ability. I understand this information may be shared with other medical offices only as necessary. I will not hold my dentist or any member of his/her staff responsible for any errors/omissions that I may have made on this form. I will notify the office should any information change in the future.

PRINT NAME	SIGNATURE	DATE
Sharla Aronson, DDS		
DENTIST	SIGNATURE	DATE

OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere.
Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- *For patients with Dental Insurance:*
  - **We are happy to file the forms necessary to see that you receive the full benefits of your insurance coverage; however, WE CANNOT GUARANTEE ANY ESTIMATED COVERAGE. Your insurance policy is an agreement between you, your insurance company, and your employer. We ask that all patients accept direct responsibility for all charges.**
  - **Services rendered are the patient's financial responsibility and the provider will bill the insurance company as a courtesy.**
  - Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
  - All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.
- Please note, for your convenience, we do accept VISA, MasterCard, Discover and Care Credit as well as checks and cash.
- If you have a direct reimbursement plan that sends a check directly to you, we ask that all fees be paid to Aronson Family Dental when services are rendered.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require a 48-hour notice. Cancellations, last minute rescheduling or failure to show may result in a broken appointment charge of $75.00, or no reappointment.**
- **If you have no-showed to two or more appointments, we will require you to call us to schedule a same-day appointment.**
- Our office will provide confirmation calls and postcards to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm your appointment. Failure to do so may result in your appointment needing to be rescheduled.
- **Certain treatment appointments may require a down payment at the time the appointment is scheduled** to hold the appointed time, as determined by Aronson Family Dental.

CONSENT

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Signature_____(Patient, Parent or Guardian) **Date** _____

Privacy Notice

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at (970) 472-0488.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Aronson Family Dental does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.
We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Aronson Family Dental maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Aronson Family Dental.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Aronson Family Dental occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Prescription Drug Monitoring Program (PDMP)

Each prescriber must disclose to patients for whom he/she is prescribing a controlled substance that the patient's prescription information will be loaded into the PDMP and may be queried by authorized individuals. Each pharmacy must disclose to patients who are receiving controlled substances that their prescription information will be loaded into the PDMP and may be queried by authorized individuals.

PATIENT ACKNOWLEDGEMENT

I _____have reviewed Aronson Family Dental's Privacy Policy.

Signed_____ Date _____

Last Updated June 2017