MACRI DENTAL LLC
303.694.0585
5420 South Quebec Street Suite 203
Greenwood Village, CO 80111

Personal Information

Patient Name

_____
First Middle Last

Address

_____

City _____ State _____ Zip _____

Birthday _____ /_____ /_____

Home _____

Work _____

Cell _____

Social Security _____-_____-_____

E-mail _____

Emergency Contact

Name _____

Relation _____

Phone Number _____

How did you hear about us or who referred you?

_____

Employer Information

Employers Name _____

Phone Number _____

Address_____

City _____ State ____ Zip _____

Full time student Yes _____ No _____

Insurance Information

Primary Insurance:

Subscriber Name _____

Subscriber SSN _____

Subscriber Date of Birth _____

Relationship to Subscriber _____

Insurance Company _____

Insurance Phone _____

Member ID _____

Secondary Insurance:

Subscriber Name _____

Subscriber SSN _____

Subscriber Date of Birth _____

Relationship to Subscriber _____

Insurance Company _____

Insurance Phone _____

Member ID _____

Release of Information

_____ I authorize to release my protected Health Information to the person(s) listed below. These individuals are family and/or trusted friends that Macri Dental has my permission to share my dental care, treatment, and billing matters with upon their verbal or written request.

Name _____
Relation _____
Phone _____

Name _____
Relation _____
Phone _____

_____ I DO NOT authorize information to be released to anyone.

**I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by notifying Macri Dental in writing.*

Messages

Macri Dental offers E-mail and Text Message notifications for Appointment Reminders and other patient care related information. This system will allow you to verify appointment at a time convenient to you, to request future appointments, and to keep you informed of office and patient care information. If you choose to opt-in to this system please provide us with your email and phone number. This information is only used for Macri Dental purposes and is governed by the same HIPAA protection as all other information.

_____
Patient Name (Print) Date

_____
Patient Signature (or responsible party)

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Medical History

Patient Name _____ DOB _____

	YES	NO
Have you been hospitalized in the past two years?		
Are you currently taking any medication? **If so, what?**		
Are you allergic to any drugs or medications? What happens when you take that medication?		
Have you had any excessive bleeding requiring special treatment?		

Do you have or have you had any of the following? (Please check all that apply to you)

Heart Problems		Stroke		AIDS/HIV positive		Osteoporosis	
High Blood Pressure		Kidney Trouble		Hepatitis A		Drug Addiction	
Low Blood Pressure		Cancer		Hepatitis B		Hemophilia	
Rheumatic Fever		Tuberculosis (TB)		Hepatitis C		Cold Sores	
Artificial Joints		Diabetes		Psychiatric Treatment		Epilepsy or Seizures	

Please list any disease, conditions, or problems that you had or have that are not listed.
Please list:

Do you use any of the following products? (Please check)

__Cigarettes __Alcohol __Cigars __Chewing Tobacco __Pipe __Snuff __Marijuana

WOMEN: Please circle

Are you Pregnant now?		Are you taking Birth Control?		Do you anticipate becoming pregnant?	
Yes	**No**	**Yes**	**No**	**Yes**	**No**

When was your last dental exam?
Is there anything you would like to change about your smile?
Are you interested in straightening or whitening your teeth?

What is the most important to you: (please circle one)

1. Cost/Affordability
2. Trust/Relationship
3. Time/Convenience
4. Comfort/Pain
5. Quality/Esthetics
6. Other _____

_____
Patient Name (Print) Date

_____
Patient Signature (or responsible party)

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Office Financial Policies

Dental insurance plans do not normally provide full coverage of your dental bill. Your dental coverage is a contract between you and your insurance company. While we will cooperate to the fullest in expediting your claim, you are ultimately responsible for your account. **Your portion of the bill will be due at time of service, unless otherwise previously agreed to a written payment plan agreement.** If your insurance has not paid within 60 days from the date of service, we will look to you for prompt payment of the account. All costs for collection of the account, should collection procedures or small claims court become necessary, will be passed on to the patient and/or the responsible party. I understand that due to any false information, I may be subject to criminal prosecution.

Initial _____

Assignment of Benefits

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Macri Dental**.**

Initial _____

Insurance Regulations

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or 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 by law, I consent to your use and disclosure of my protected health care information to carry out payment activities in connection with claims submitted from this office.

Initial _____

Cancelation Policy

We do require a 48 hour notice for any appointment changes to avoid a $50 cancellation fee.

Initial _____

HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I am authorizing you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice
- Methods of payment, including credit card information (although encrypted) will be kept safe and protected

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Notice of Privacy Practices (**must be signed by ALL patients**). By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

_____

Patient Name (Print) Date

_____

Patient Signature (or responsible party)