PATIENT INFORMATION

DATE ____
Date of Birth __________________________________
Name____ Preferred Name ______________________________
Last First MI
Social Security #____________________________
❑Married ❑Single ❑Minor ❑Male ❑Female
Address____
Street Apt. # City State Zip
Phone____ E-mail____
Name of Employer______________________________________ Employer phone_______________________________
Cell Phone ____ May we call you at work (circle one) Yes No
Person Responsible for account (please check one) ❑Patient ❑Guardian ❑Spouse ❑Father ❑ Mother

INSURANCE INFORMATION

PRIMARY INSURANCE If no insurance complete for Responsible Party	**SECONDARY INSURANCE**
Last First MI	Last First MI
Street City State Zip	Street City State Zip
Home phone# Work #	Home phone# Work #
Cell # E-mail	Cell # E-mail
Birth Date (month/day/year) Relationship to patient	Birth Date (month/day/year) Relationship to patient
Employer Dental Insurance CO	Employer Dental Insurance CO
SS# Sub# Group #	SS# Sub# Group #

PERSON TO CONTACT IN CASE OF EMERGENC Y

Name____
Phone #'s____

Has any member of your family been treated in our office?
❑No ❑ Yes Whom________________________

Whom may we thank for referring you to our office
____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby grant the right to Sunrise Dentistry to release my/my child's dental/medical history and other information about my dental treatment to third party payers/professionals.

PAYMENT INFORMATION

Payment is expected at time of service unless prior arrangements are made. Interest of 1.5% per month will be charged on all past due accounts, with a minimum of $5.00. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account or future outstanding accounts. There will be a $75.00 missed appointment fee charged to accounts that have not given 48 hours notice prior to their scheduled appointment

____ ____
Patient/Responsible Party Date

PATIENT____________________________________ Date ___________________________

Name of Physician ______________________________ Phone __________________________

Circle a definite answer for each question

Yes No Any changes in your health in the last year?

Yes No Are you currently under the care of a physician?

If yes, describe your treatment ____

Yes No Have you had any medical treatment or physician visit of any kind in the last year?

If yes, describe ____

Yes No Have you ever had any surgical operation of any kind?

If yes, describe ____

Yes No **Have you ever had a serious injury to your head or neck?**

If yes, describe ____

Do you have, have you had , or been treated for any of the following:

Yes No Arthritis

Yes No Rheumatic Fever/Scarlet Fever

Yes No Heart Problems/Attacks/Stroke

Yes No High Blood pressure

Yes No Low Blood Pressure

Yes No Heart Murmur

Yes No Heart Surgery/Pacemaker

Yes No Mitral Valve Prolapse

Yes No Difficulty Breathing

Yes No Anemia/Sickle Cell Disease

Yes No Allergy

Type______________________________

Yes No Fainting Spells

Yes No Diabetes

Type______________________________

Yes No Ulcers/Colitis

Yes No Kidney Disorder

Yes No Tuberculosis

Yes No Thyroid condition

Yes No AIDS

Yes No ARC (AIDS related complex)

Yes No Anorexia/ Bulimia

Yes No Emphysema

Yes No Latex Allergy

Yes No Sexually Transmitted Disease

Type______________________________

Yes No Hip/Joint Replacement

When______________ Dr. ______________

Yes No Screws, Pins, Plates

Yes No Hemophilia/Bleeding/Blood Disorder

Yes No Epilepsy/Seizures

Yes No Radiation/Chemotherapy

Yes No Ear Infections

Yes No Hepatitis

Yes No Cancer

Yes No Osteoporosis

Yes No Chronic sinus

Yes No Asthma

Yes No Severe/Frequent Headaches

Yes No Chemical Dependency

Yes No Any other medical conditions

Type______________________________

Yes No Have you ever had an allergic reaction or been told not to take any medication?

If yes, describe ____

Yes No Are you currently taking any prescription drug of any kind? (example-birth control, hormones, diet)

If yes, describe ____

Yes No Are you currently taking any non-prescription drugs of any kind? (example-aspirin, cough syrup, nasal spray, recreational drug use, sugar, caffeine

If yes, describe ______________________________ Daily intake___________________________

Yes No Have you ever taken Bisphosphate medication such as Fosamax, Boniva, Didronel, Zometa?

Others____

Yes No Are you Pregnant? Anticipated delivery date____________________________________

Yes No Do you use tobacco products?

Pharmacy Name_____________________________________ Pharmacy number________________________

I certify the above information to be true and correct to the best of my knowledge

Signature____ Date ___________________________________

Dr. Signature ____

DENTAL HISORY / STATUS

1. What brought you in today? ____
   Do you have any concerns or needs that you would like us to address?
   Immediately? ____
2. Did you have any trouble finding our office? ____________________________
3. Are you having any pain? Soreness? Sensitivity? Sores?
   ____
4. Last dental visits Exam_________months / Years
   Cleaning______months / years ago x-rays_____months years / ago
5. Regular cleaning schedule? Months 3 4 6 12
6. Do you have a history of gum problems? Periodontal treatments________________
   Recession, Bleeding, Pockets Floss______x per day?
7. Diet: Great Good Fair Poor Soft drinks_____Caffeine________
   Alcohol_________Sweets_________Exercise____________
8. How is your jaw? Bite: Good Fair Poor
   TMJ: Good Fair Poor
9. What has your experience been with dentistry? ______________________________
   Fear issues? ____
10. On a scale of 1-10 (1 = not at all, 10 = terrified) how nervous are you now? _________
11. Are you concerned about Mercury fillings, Root canals, Dental materials, Fluoride? Do you want your mercury filling removed? Yes / No
12. Are you satisfied with your past dentistry? Yes / No
13. How do you do with dental treatment? Ok Fear
    Hate……..noise / drilling……..vibration……tastes…..EVERYTHING
    If fearful…….use Nitrous? ____ Sedation? ______
    Difficult numbing? ________ Difficult staying open? _________
14. What is there about your general health or past dental history that would be helpful for optimal Dental care? ____
15. Would you be interested in Whitening your teeth or improving your smile? Yes / No

What would you like for your teeth / mouth long term? _______________________

GENERAL CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include relief from pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (Paresthesia).** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or join tenderness**. Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity** or pain in teeth or gums, infection or bleeding
5. **Swallowing** or inhaling small objects

While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you

I have read and understand the statement on this page.

______________________________ ______________________________
Patient's Signature Date

______________________________ ______________________________
Parent's Signature (if a minor patient) Date

Sunrise Dentistry

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEATLH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF OUR 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 rights 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 2/25/02 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 this 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 health care provider providing treatment to you.

Payment: We may use and discuss your health information to obtain a 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 our 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 authorization, you may revoke it in writing at any time. Your revocation 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, 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 forms 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 have reasonable belief that you are a possible victim of domestic abuse, neglect or domestic violence or the possible victim of 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 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 look at 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 charge you 0.00 for each page plus $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 alternate 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 six years, but not before April 3, 2003. If your 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

Alternate 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 locations, and provide satisfactory explanation how payments will be handled under the alternative means or location request.

Amendment: You have the right to 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 Website by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy 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 of 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 bottom 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.

Contact Officer: Dale G. Strietzel, D.D.S.

Telephone: 970-247-3303

Address: 1911 Main Avenue, Suite 116
Durango, Co 81301

SUNRISE DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I____ have received a copy of this office's Notice of Privacy Practices.

Please Print Name ____

Signature ____

Date ____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of 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) ____