

PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ Today's Date: _____

Preferred Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (C): _____ (H): _____ (W): _____

Email: _____

SSN: _____ Employer: _____

Is the Patient the Responsible Party for Payment? Yes No If no, please fill out the information below.

Responsible Party Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (C): _____ (H): _____ (W): _____

Email: _____

SSN: _____ Employer: _____

Reason for your Visit:

Exam/Cleaning Emergency Consultation Invisalign Other

If other, please explain: _____

Do you require antibiotic premedication prior to dental treatment? Yes No

Are you currently experiencing any dental pain? Yes No

If so, where and for how long? _____

Please check the corresponding box if you are currently experiencing any of these problems:

- | | |
|--|--|
| <input type="checkbox"/> Red, Swollen or Bleeding Gums | <input type="checkbox"/> Swelling/Lumps in Mouth |
| <input type="checkbox"/> Sensitive Teeth or Gums | <input type="checkbox"/> Blisters or Sores in/around the Mouth |
| <input type="checkbox"/> Lost/Broken Fillings or Teeth | <input type="checkbox"/> Burning Tongue/Lips |
| <input type="checkbox"/> Loose/Shifting Teeth | <input type="checkbox"/> Stained Teeth |
| <input type="checkbox"/> Food Caught between Teeth | <input type="checkbox"/> Bad Breath |

My teeth are sensitive to:

- Hot Cold Sweets Biting/Chewing

Approximate date of last dental exam/x-rays: _____

How many times a day do you brush? _____

How many times a day do you floss? _____

Do you use an electric or manual toothbrush? _____

On a scale of 1 – 10, (10 being very healthy) how would you rate your general health? _____

Please mark all that apply to you:

- | | | |
|---|---|--|
| <input type="checkbox"/> Locking Jaw | <input type="checkbox"/> Limited Jaw Opening | <input type="checkbox"/> Jaw Joint Pain, Clicking or Popping |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> Ear Congestion |
| <input type="checkbox"/> Difficult Swallowing | <input type="checkbox"/> Clenching/Grinding | <input type="checkbox"/> Difficulty Chewing |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Neck/Shoulder Pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Postural Problems | <input type="checkbox"/> Tingling Fingertips | <input type="checkbox"/> Nervousness/Insomnia |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Trigeminal Neuralgia | |

Signature of Patient, Parent, or Guardian Print Name Date

Relationship to Patient: _____

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Patient Name: _____

Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes _____

Have you ever been hospitalized or had a major operation? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Are you taking any medications, pills, or drugs? Yes No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics
 other) If yes _____
 Do you use controlled substances? Yes No If yes _____

Do you have, or have you had, any of the following?

AIDS/HN Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed Yes No If yes _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____

Date: _____

HANDLE ME WITH CARE

Name: _____

Date: _____

We want you to be comfortable during your visit, so please put a checkmark next to the statement that describes how you feel about going to the dentist and your overall care. Check as many as you like.

- I gag easily.
- I feel out of control while lying in the dental chair.
- I have a problem with being tipped back in the dental chair.
- I am very anxious about injections.
- I hate the noise of dental instruments.
- I have not been seen by a dentist for a long time and I am worried about what you will tell me about my dental hygiene.
- I am embarrassed about the way my teeth look.
- I have had a bad experience and I have a lot of fear which has kept me from getting the dental care I need.
- I am very apprehensive about the possibility of experiencing pain.
- I have difficulty listening and remembering when I am in the dental chair.
- I want to be able to ask as many questions as necessary so that I understand why and what treatment is being recommended for me.
- I would like to see pictures and videos that will help me understand my dental problems and possible solutions.
- There are other concerns I would like to talk about: _____



COMMUNICATION CONSENT FORM

Patient Name: _____

In order to comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, we ask that our patients review and sign this Communication Consent Form.

Dr. Sarah Meyer and Dr. Kha Nguyen will not release confidential and/or other Protected Health Information (PHI) in any written or recorded manner unless authorized by you to do so. Additionally, information will not be left with an unauthorized person who may answer the telephone or call in on your behalf.

I, _____, authorize Cherry Creek Dental Group to contact me and/or my named authorized person(s) to convey PHI by the following methods and assume responsibility to notify Cherry Creek Dental Group whenever this information changes:

Email on record: [] Yes [] No Home Phone on record: [] Yes [] No
Home Address on record: [] Yes [] No Cell Phone on record: [] Yes [] No

Who may we contact in case of an emergency?

Name: _____ Relationship: _____

Phone Number: _____

Please tell us who is authorized to receive protected information about your care:

Emergency Contact Listed above: [] Yes [] No

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature

Date

Parent/Guardian Signature

Date

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CHERRY CREEK DENTAL GROUP OFFICE POLICY

Patient Name: _____

It is the goal of this office to provide you with the finest quality dental care possible. We believe that a clear definition of our financial and insurance policies will allow the patient, doctor and staff to concentrate on the most important issue—regaining and maintaining your dental health.

Payment for Services:

We require payment in full for all services rendered at the time of visit, unless other arrangements have been made in writing with our business manager. If an account is not paid within 90 days of the date of service and no financial arrangements have been agreed upon, you will be responsible for legal fees, collection agency fees, interest charge and any other expenses occurred in collecting your account.

Missed Appointments:

If you need to reschedule or cancel your appointment, we require 48 hours advance notice to ensure we are able to best meet the needs of our patients that want in sooner. If you provide less than 48 hours advance notice, you will be charged a \$50.00 per hour missed appointment fee.

Dental Insurance:

As a courtesy to you, we will file your dental insurance claims for you. By signing this office policy, you are assigning all insurance benefits to us. Any deductibles and estimated co-payments must be paid on the day of service. If you prefer to submit your own dental claims, payment in full will be required on the day of service and you shall be provided with a copy of the statement.

Insurance Payments Only an Estimate:

Please understand that we are only able to estimate your insurance company's payment based on the information your insurance company provides us. Your dental insurance policy is a contract between you, your employer (if it is a group dental plan) and the insurance company. The dentist is not a party to the dental insurance contract. We do not guarantee that your insurance company will reimburse for services at the usual and customary fees nor does your insurance company guarantee the accuracy of benefits quoted to us by phone, fax, or online.

Balance Due:

Not all dental services are covered benefits in all dental (or medical) insurance contracts. The filing of insurance claims is a courtesy that we extend to our patients; however, all charges are your responsibility from the day services are rendered regardless of insurance coverage. Any balance due after an insurance payment is received is your financial responsibility and a bill will be sent to you within 30 days after receiving insurance payment. Any payment received in excess of your balance will be credited to your account. We will refund of any credit balance upon your request using the original method of payment, with the exception of cash payments which will be refunded via check. If you prefer you may also use this credit toward any future services with us instead.

Refund Policy:

There is a significant amount of time, professional resources and costs associated with providing a patient with a customized treatment plan. Additionally, there are hard costs that are incurred for aligners, crowns, bridges, prosthetics, device's and oral appliances which are custom designed and manufactured for each patient and may be integral to the overall treatment provided. Because of this, Cherry Creek Dental Group does not issue refunds on products or services. We realize that circumstances may arise from time to time that require special consideration, therefore Cherry Creek Dental Group reserves the right to review any case on an individual basis and at our sole discretion.

By my signature below I acknowledge I have read and consent to the above policies, conditions of treatment and payment:

Signature of Guarantor of Payment/Responsible Party

Date

Patient Name: _____ Relationship to Patient: _____

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CONSENT FOR SERVICES

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

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 authorize Cherry Creek Dental Group to use and disclose my protected health information to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third-party payers (i.e. insurance companies) or other financial institutions (i.e. credit card companies, financing companies);
- The day-to-day healthcare operations of Cherry Creek Dental Group.

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 Cherry Creek Dental Group 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 Cherry Creek Dental Group is not required to agree to these requested restrictions. However, if Cherry Creek Dental Group do agree, then Cherry Creek Dental Group is 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.

I authorize Cherry Creek Dental Group to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

Signature of Patient, Parent, or Guardian

Date

Patient Name: _____

Relationship to Patient: _____

Office Use Only: Entered by: _____ Scanned by: _____ Date: _____