Willow Run Dental, P.C.

Patient Health Record.

Date:_____

Name: (Last)_____(First)_____(MI)_____
Nickname:_____Address:_____
City:_____ Zip:_____ Home PH#:_____
Cell #:_____Email Address:_____
SS#_____ Date of Birth:___/___/___ Sex: M/F Marital Status S/M/W/D
Referred By:_____
Employer:_____ Work Ph#:_____
Spouse's Name: (Last)_____(First)_____(MI)_____
SS#_____ Date of Birth ___/___/___ Cell #_____
Employer:_____ Work Ph#:_____
Dental Insurance:_____Group#:_____
Name Insurance is under:_____ Ins. Ph#_____
Relationship to insured:_____

Medical Health

General health (Please check one): Excellent_____ Good_____ Fair_____ Poor_____
Name and address of Physician:_____
_____Phone #_____
Last Physical Exam:_____ Are you taking any medications now? Y/N
If 'yes', please list name and for what purpose:_____
_____.
If more space is needed, **check here**____ and use back of this page for that purpose.
Have you ever been treated for?

Heart Disease…Y/N	Heart Murmur…Y/N	Jaundice……..Y/N	Ulcers……..Y/N
Diabetes……Y/N	Epilepsy……..Y/N	Anemia…….Y/N	Cough……..Y/N
Arthritis……Y/N	Osteoporosis…..Y/N	Stroke……Y/N	Glaucoma..Y/N
Sinus trouble….Y/N	Asthma……..Y/N	Hay Fever…..Y/N	HIV……..Y/N
Hepatitis ABC… Y/N	Tuberculosis..... Y/N	Lung Disease..Y/N	

Do you require Dental Pre-Medication Antibiotic?.... Y/N Covid-19 Vaccine.... Y/N

Have you had any surgery with instrumentation placed? If yes, when and what type?
_____.
Have you ever been treated (other than diagnostic) with X-Ray? Y/N if 'yes' for what purpose?
_____.
Are you allergic to: Penicillin_____ Codeine:_____ Local injected anesthetics_____
Other medications?_____
Are you subject to prolonged bleeding? Y/N Are you subject to fainting spells? Y/N
Do you have excessive urination and/or thirst? Y/N
(Women) Are you pregnant Y/N If yes, how many weeks?_____

Dental Health

Reason for visit?_____
When was your last dental exam?_____
Have you ever had any serious problem associated with previous dental treatment? Y/N
If yes, please Explain_____

How often do you brush your teeth?_____ How often do you floss?_____

What texture of toothbrush do you use? Hard_____ Medium_____ Soft_____

Do your gums bleed while brushing? Y/N
Do your gums bleed while flossing? Y/N
Do you feel pain to any of your teeth when brushing or flossing? Y/N
Do you avoid brushing any part of your mouth because of pain? Y/N
Do you feel twinges of pain when your teeth come I contact with:

A. Hot foods or liquids, ***i.e.,*** Soup, coffee, tea, etc……..Y/N
B. Cold foods or liquids, ***i.e.,*** Ice cream, cold fruit, ice water, etc……..Y/N
C. Sweets, ***i.e.,*** Candy, fruit, sweet desserts, etc……Y/N
D. Sours, ***i.e.,*** Lemons, limes, grapefruit, etc……Y/N

Do you chew on only one side of your mouth? Y/N If yes, explain_____
Do your gums feel tender or swollen? Y/N
Do you clench or grind your teeth while sleeping or during the day? Y/N
Do your jaws ever feel tired? Y/N If yes, When?_____
Do you wear dentures? Y/N
Do you usually have many cavities Y/N
Do you lose fillings or break filings? Y/N
Do you gag easily? Y/N
Are you familiar with the term, "Preventative Dentistry"? Y/N
Please add anything you feel is important:_____

Signature on File:
I, (your name)_____ give my permission for Dr. McMurtrey's office to file my insurance. My signature at the bottom of this form authorizes them to do so.

Insurance and Financial Policy:
I have read the insurance and financial policy for this office and understand and agree to its terms.
(Your initials)_____

HIPPA Policy:
I have read and understand the HIPPA policy for Willow Run Dental, PC.
(Your initials)_____

Willow Run Dental, P.C.

Insurance and Financial Policy

Insurance Billing:

As a courtesy to our patients we will file your insurance. Patients are responsible for knowing their own insurance coverage. We will bill an insurance company only twice for each service. IE: Original billing date, and resubmit per service if necessary. We can only wait 60 days for the insurance payment; our computer system automatically deletes the insurance claim at 61 days. After 61 days the unpaid balance is the patients' responsibility. An itemized statement will be mailed to the patient and it the patient's responsibility to resubmit their insurance for reimbursement.

The patients estimated portion is expected at the time of service. If the amount due from the patients is more than can be paid, payment arrangements can be made with our front office staff.

Financial Arrangements:

The previous patient balance and payment history determines the arrangements that can be made. For routine dental care the patient's portion is due at the end of your appointment such as, fillings, simple extractions and dental supplies. However payment is due at the **beginning** of your appointment for root canal therapy, RPC Treatments, teeth bleaching, wisdom tooth extractions, crowns, bridges and any other prosthetics. Our front office staff will give you an estimate of your portion, when you are scheduling your appointments.

Finance Charges:

After 30 days finance charges are automatically applied to accounts at a rate of 1.5% per month, or 18% annually.

Custodial parent/Financially responsible parent: It is the policy of our office that the parent that brings their children into the office is the parent who is financially responsible to our office. We will bill insurance in the manner explained above, but will not bill a third party for any balance due. We understand that all families have different familial arrangements and try to be respectful to that. This policy comes out of much care and consideration for all parties involved.

Changes:
This financial policy is subject to change at any time at the discretion of Dr. McMurtrey

I have read and understood the financial policy as explained above.

Signature_____Date_____

10/22/2010 CM

Willow Run Dental, PC
12910 Zuni St., Ste 600
Westminster, CO 80234

Willow Run Dental Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Willow Run Dental, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example; a review of your file by a Dental or Medical specialist whom we may involve in your care.

We may use or disclose your health information for payment of your services by your insurance company. We may use of disclose your health information for our normal healthcare operations; i.e. entering your information onto our computer. We may also use it to contact you about appointments and may leave information with someone who answers your phone or leave information on an answering machine. We may also use it to send you newsletters or other information or other information. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

We may share your dental information with business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

In an emergency, we may disclose your information to a family member or someone responsible for your care.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. We may release some or all of your health information when required by law.

You may request in writing that we do not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a verbal or written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies. Colorado law says that we must provide access or copies within a "reasonable amount of time".

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing if you wish to include a statement in your file, please give it to use in writing. We may or may not make changes to your request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information. You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing. For more information regarding your health information privacy, please contact our Office Manager, Christa at (720)872-2750.

Signature_____Date_____