Welcome to Ross Family Dentistry!

Please complete and bring to your first appointment

Patient Information

Patient Name____Date____________________

Street Address____________________________________City___________State_____Zip Code_______

Home Phone_________________ Cell Phone___________________ Work Phone___________________

Email Address (please provide)____

Social Security Number________________________ Date of Birth______________ Marital Status_________

Emergency Contact Name______________________ Emergency Contact Phone Number___________________

Whom may we thank for referring you to our practice?____

Patient Employment Information

Employer___________________________________Do you have dental insurance through this employer?_________

If yes, please provide us with a copy of your insurance card.

Financially Responsible Party Information

Name______________________ Address if different than above____________________________________

Home Phone__________________ Cell Phone______________________ Work Phone______________

Social Security Number_______________ Date of Birth______________ Relationship to Patient____________

Employer__________________________ Do you have dental insurance through this employer?__________

If yes, please provide us with a copy of your insurance card.

Dental Insurance Information

Primary Dental Insurance

Insurance Company_____________________

Insurance Company Phone Number_____________

Subscriber/Member or Policy Holder Info:

Name________________ Date of Birth_______

Social Security #_________________________

Group number_____________ Is it a PPO Plan?___

Secondary Dental Insurance (if applicable)

Insurance Company_____________________

Insurance Company Phone Number_____________

Subscriber/Member or Policy Holder Info:

Name________________ Date of Birth_______

Social Security# _________________________

Group number_____________ Is it a PPO Plan?___

Financial Agreement and Office Protocols

Patients are responsible for all charges in our office, including broken appointments that are not cancelled within two business days' notice. The broken appointment fee is $55 per hour of reserved appointment time scheduled, with less than two business days' notice of cancellation. Payment is due when services are rendered. We suggest that you pay your services in full and have your insurance company reimburse you directly, since all claims are submitted immediately for prompt processing. However, we will gladly submit your claims to your insurance company and collect the **estimated** patient portion, including any deductibles for your services at time of service. All account balances over 30 days are subject to a 1.6% per month finance charge (19.2% APR). There is a $35.00 fee for any returned checks. I authorize and request my insurance company to pay directly to Ross Family Dentistry any insurance benefits due to Ross Family Dentistry for services rendered. I verify that I am solely responsible for all charges not covered by my insurance company and agree that any amounts not paid by my insurance company or companies within 45 days of initial date of service, will be transferred to me and are due immediately to Ross Family Dentistry.

If you pay what we **estimate** your co-pay, and deductible to be, please be aware that we can only **estimate** what those amounts are, based upon the information provided to us by your insurance company. Your insurance company will pay only to the limits or maximums of its contract with you and or your employer. The details to those contracts are unknown to us, as well as your individual or group benefit plan package. It is the patient's and/or the policy holder's responsibility to be aware of any restrictions, limitations, exclusions, alternate benefits, allowables, frequencies and downgrades. It is important for you the patient, policy holder and/or responsible party to become familiar and aware of your specific plan benefits and guidelines. You are solely responsible for any balance left unpaid by your insurance company.

To assist our patients, we offer the following methods of acceptable payment: Cash or check, Visa, MasterCard or Discover. We will also accept your HSA (Health Savings Account) or Flex-Spending Benefit Card. For patients that qualify, we offer a 6 or 12 month interest- free payment plan (when balance is paid within the 6 or 12 month period) through Care Credit. There are no upfront costs, pre-payment penalties or annual fees associated with Care Credit to our patients .

HIPPA Information – Notice of Privacy Practices

You have the right to read the Notice of Privacy Practices which provides a description of office treatment, payment activities and healthcare operations of the uses and disclosures we may make to your protected health information, and other important matters about your protected health information. We may disclose your health information to a physician or other healthcare provider providing treatment to you. We may use your photos for demonstration purposes. You have a right to look at or get copies of your health information, with limited exceptions. I grant my permission to you or your assignees, to telephone me at home, on my cell phone or at my place of employment to discuss matters related to this form. We will gladly provide you with a copy, in its entirety of the Notice of Privacy Practices disclosure form upon your request.

I have read all of the conditions of the Consent for Treatment, Financial Agreement and Office Protocols, HIPPA Information-Notice of Privacy Practices, and have accurately provided our office with current and updated information including but not limited to insurance coverage information and medical health conditions, as acknowledged by my signature below.

Consent for Treatment

I request and authorize Dr. Anne Ross, and or such persons as she may appoint, to provide treatment, to perform or assist in the performance of dental treatment or procedures in our office.

It is understood that unforeseen conditions or circumstances may arise during the course of treatment, therefore I consent to and authorize the performance of any care, procedure, or treatment that Dr. Anne Ross deems necessary or advisable as a result of any unforeseen events, conditions or circumstances that may arise during the course of treatment.

I consent to the administration of any anesthetic that Dr. Anne Ross (or her appointees) deem necessary to provide the proper treatment and to help ensure your dental treatment to be a comfortable experience.

I have been given the opportunity to refuse to consent to any and all treatment or procedures either verbally or in writing. I certify that I have read and understand all of the above, and acknowledge this by my signature below.

____ ______________________________

Signature of Patient, Parent or Legal Guardian of Patient **Date**

Health History

Medical History

Name of family physician:____ Phone #:____________________

Are you in good health? ____

Have you ever had any of the following? (Please circle)

Arthritis	HPV	High Blood Pressure
Hepatitis (type)___	Blood Disease	Heart Disease
Prolonged Bleeding	Glaucoma	Heart Murmur
Stroke	Lung Disease	Depression/Anxiety
Rheumatic Fever	Diabetes	Ulcers
Liver Disease	Mental Disorders	Tumor history
Fainting Tendency	Thyroid Disease	Radiation Therapy
Anemia	Kidney/Bladder Problems	Chemotherapy
Chest Pain	Sinus Trouble	Bleeding Disorder
Tuberculosis	Venereal Disease	Artificial Joints (type)____________
Epilepsy	Shortness of Breath	(replacement date)_____________
HIV or AIDS	Asthma/Hay Fever	

Please list all medications you are taking, including any over-the-counter medications:____
____
____
____
____
____

Have you *ever* taken any bisphosphonate medications? (Fosamax, Actonel, Boniva, Zometia, etc.) ____

Please list any recent surgeries or hospitalizations.

____
____
____
____
____

Phone: (970) 667-1236 | Fax: (970) 278-0365 | Email: info@ross-family-dentistry.com

Dr Anne E Ross, DDS
1907 Boise Ave, Ste #5
Loveland, CO 80538

Health History (cont.)

Do you have any health problems that need further clarification? If yes, please explain____

Have you ever been told that you need to be pre-medicated before dental treatment? ____

Have you used drugs other than those required for medical reasons?____

Do you use alcohol? ___Never ___1-3 drinks/week ___4-6 drinks/week ___7+ drinks/week

Do you use tobacco?________________ How much?____________________________

Do you use marijuana?______________ How much?____________________________

Allergies: Have you had an allergic reaction to any of the following? (Please circle)

Penicillin Erythromycin Tetracycline Dental Anesthesia Aspirin Codeine Sulfa Latex Jewelry/Metal

Medications/Other (please list)____

For Women: Are you pregnant?_________ Think you may be pregnant?__________ Are you breastfeeding?__________

Are you taking birth control?_________

Should you have a change to your health history, or are taking any new medications, please notify the doctor at your next appointment.

Dental History

How long has it been since you've seen a dentist?____

Have you had regular dental check-ups?____

Do you have any dental concerns now?____

Do you think your overall dental health is: ______Good ______Fair ______Poor

Have you ever been told you have gum problems or periodontal disease?____

Have you ever had gum surgery?____

Has there been a change in the fit of your partial or complete denture?____

Have you been told you grind or clench your teeth?____

Do you want to change anything about your smile? (Appearance, Position, Shape, Shade)_______________________________________

Are you apprehensive about dental treatment?____

Have you ever had any complications following dental treatment? ____

Is there anything else you would like us to know? ____

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Dental Appointment Agreement

It is very important for you to keep your scheduled dental appointments. Broken appointments result in lost time that could have been used to treat other patients in need.

Rescheduling Appointments

Dr. Ross and her staff understand that sometimes situations arise that require rescheduling of your appointment. If you do need to reschedule, please contact our office as soon as you know that you will not be able to keep the appointment, preferably two business days' notice before your scheduled appointment time.

Broken Appointments

If you happen to miss a scheduled appointment or cancel the appointment with less than two business days' notice, a charge of $55.00 per hour of reserved appointment time may be accessed to your account. Our business hours are Monday through Thursday from 8:00am to 5:00pm.

If you arrive late for your scheduled appointment, you may be asked to reschedule if there is not enough time to complete your procedure. We do make every effort to be on time for your appointments, and appreciate the same courtesy from our patients.

We appreciate your understanding and acknowledgement of the Dental Appointment Agreement, thank you!

____

Patient Name (please print)

____ **Date**____

Signature of Patient, Parent or Legal Guardian of Patient

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