JAMES C. CALVIN, D.D.S., P.C

Patient's Information (PLEASE PRINT)

Email _____
(PLEASE PRINT)

Date _____

Name _____ Home Phone _____

Address _____ Cell Phone _____

City/State/Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____

Patients SS# _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation _____

Employer _____

Employers Address _____

Employers Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____ Phone _____

How did you hear about our office? _____

Best time and place to reach you _____

Can we call you to confirm your appointment? ☐ Yes ☐ No Can we leave a message? ☐ Yes ☐ No

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____ Group # _____

Is Patient covered by additional Insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Dental History

Reason for today's visit _____

Date of last dental visit _____

	Yes	No		Yes	No
Burning sensation of tongue	☐	☐	Mouth Breathing	☐	☐
Chew on one side of mouth	☐	☐	Mouth pain, brushing	☐	☐
Cigarette, pipe or cigar smoking	☐	☐	Orthodontic Treatment	☐	☐
Clicking or popping jaw	☐	☐	Pain around ear	☐	☐
Dry Mouth	☐	☐	Periodontal treatment	☐	☐
Loose teeth or broken fillings	☐	☐			

Health History

Physician's Name _____

Date of last visit _____

Please mark "Yes" or "No" to indicate if you have had any of the following:

	Yes	No
AIDS	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial Heart Valves	☐	☐
Artificial Joints, Where_____	☐	☐
Asthma	☐	☐
Bleeding abnormally, with extractions or surgery	☐	☐
Blood Disease	☐	☐
Cancer, Type_____	☐	☐
Chemical Dependency	☐	☐
Chemotherapy	☐	☐
Circulatory Problems	☐	☐
Cold Sores	☐	☐
Congenital Heart Lesions	☐	☐
Cortisone Treatments	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Fainting or dizziness	☐	☐
Glaucoma	☐	☐
Headaches	☐	☐
Heart Murmur	☐	☐
Heart Problems	☐	☐
Hepatitis, Type_____	☐	☐
High Blood Pressure	☐	☐
HIV Positive	☐	☐
Jaundice	☐	☐

	Yes	No
Jaw Pain	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Mitral Valve Prolapse	☐	☐
Nervous Problems	☐	☐
Pacemaker	☐	☐
Women: Are you pregnant?	☐	☐
Due date_____		
Are you nursing?	☐	☐
Psychiatric Care	☐	☐
Radiation Treatment	☐	☐
Respiratory Disease	☐	☐
Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Shortness of Breath	☐	☐
Sinus Trouble	☐	☐
Skin Rash	☐	☐
Special Diet	☐	☐
Stroke	☐	☐
Swelling of Feet or Ankles	☐	☐
Swollen Neck Glands	☐	☐
Thyroid Problems	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head or neck?	☐	☐
Ulcer	☐	☐
STD	☐	☐
Weight Loss, unexplained	☐	☐
Blood Transfusion, When _____	☐	☐
Other _____	☐	☐

Medications

List medications you are currently taking:

_____

_____

_____

_____

Allergies

☐ None

☐ Aspirin

☐ Barbiturates (Sleeping pills)

☐ Codeine

☐ Iodine

☐ Local Anesthetic

☐ Penicillin

☐ Sulfa

☐ Latex

☐ Other _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

CONSENT: As the undersigned, I hereby authorize the Doctor to, after thorough explanation, take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated (after they are discussed with me) and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that it is my responsibility to understand the terms and limitations of my insurance. I also understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine, due and payable at the time services are rendered.

_____ _____

SIGNATURE OF PATIENT, PARENT OR RESPONSIBLE PARTY RELATIONSHIP TO PATIENT

Dr. James Calvin DDS

We wish to extend a very warm welcome to our dental office! Thank you for choosing us! We will do everything we can to make your visit comfortable. Please don't hesitate to let us know if you need anything or if there is any part of your visit we can improve on.

Patient Appointment Policy

We will do everything in our power to honor your appointment time because we realize that your time is valuable. Please understand that occasionally there are emergencies which are beyond our control that may cause a delay in your appointment. **We ask that you give us a minimum of 24 hours cancellation notice. There is a $56 per hour cancellation fee for missed appointments if you have not cancelled 24 hours in advance.**

Office Hours

We realize that emergencies sometimes cannot wait so if we are closed, leave a message with our answering service and they will contact Dr. Calvin. An emergency would include pain, swelling or trauma.

Monday- 8am to 5pm
Tuesday- 8am to 5pm
Wednesday- 8am to 5pm
Thursday - 8am to 5pm
Friday- 8am to 2pm
Saturday- 8am to 2pm
Sunday-Closed

****Rotating Schedule Hours Posted on Website****

Financial Options

Payment is due at the time of service. If you need to make payment arrangements, please speak with the our Patient Care Specialists. We have a couple financial options to assist you with your payment.

- If you have dental insurance, your benefits will be processed according to the provisions of your plan. Our Patient Care Specialists will gladly assist you in obtaining the benefits to which you are entitled under your plan.
- Dental insurance is a contract between you and your insurance carrier, not between the insurance carrier and this office. While we will assist you in receiving the maximum insurance benefit allowed, our office cannot guarantee that your insurance company will pay for treatment you receive at our practice. **Should your claim be denied, you will be responsible for payment in full at that time.**
- Insurance payments are usually received within 30 days from the time the claim was submitted. Should your insurance company not reimburse our office within 60 days, we ask that you pay the balance at that time and seek reimbursement from your insurance company yourself.

- While our office will not enter into disputes over claims with insurance companies, we will gladly provide any additional information they may request. The ultimate responsibility for resolution lies with you, the patient.
- Unless you intend to pay in full for treatment as it is rendered, our office policy requires that the patient assign payment of the allowable insurance payments to our office by signing the agreement below. This is called assignment of benefits.
- All costs incurred as a result of our collection efforts, including court costs, will be assigned to the responsible party.
- In case of default payment, I agree to pay any and all costs of collecting this account including but not limited to attorney fees and court costs.

I authorize assignment of benefits of my dental insurance benefits to Dr. James Calvin. This assignment of benefits shall be deemed ongoing until my dental insurance carrier receives written notice from me that I have revoked the agreement.

Privacy Policies and Practices

Our practice is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept to our practice. We may, from time to time, amend our privacy policies and procedures but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and the state of Colorado. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone even family members- without your consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secured from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to; provide our standard of quality care, implement payment activities, conduct normal dental practice operations and comply with the law. This may include your name, address, phone numbers, social security number, employment data, medical history, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing purposes without our written consent. We may use / disclose your health information, such as the need for premedication, to communicate reminders about upcoming appointments including voicemail messages, answering machines and postcards.

Patient Rights

You have the right to request copies of your healthcare information, all requests must be in writing. We may charge for your copies in an amount allowed by law, for example, a copy of your x-rays is a $13.00 charge. If you believe your rights have been violated, we urge you to notify us immediately. You may also notify the US Department of Health and Human Resources. We thank you for entrusting us with your dental health. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Consent to the Use and Disclosure of Health Information

I understand that as part of my dental care, this organization originates and maintains health records describing my health history, symptoms,examination and test results, diagnosis, treatment and plans for future care. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication to other health professionals that contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually done
- A tool for assessing quality and reviewing the competence of healthcare professionals

I understand and have read the ***Privacy Policies and Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the organization reserves the right to change their notice and practices. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my healthcare information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing.

_____ **I give you permisslon to share my personal health/dental information with my:(please write their name next to relation)**

Spouse:

Domestic partner:

Legal representative:

Guardians of minor children:

Including disclosure of information to confirm treatment, appointments and financial arrangements. (Please initial if applicable)

I request the following limitations on the disclosure of information:_____

_____

Signature of Patient, Legal representative, or parent

_____

Witness Date

I HAVE READ AND UNDERSTAND THE ASSIGNMENT OF BENEFITS, TERMS AND CONDITIONS AS WELL AS THE MANAGED CARE CONTRACT AND OFFICE POLICIES. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DOCTOR.

_____

Print Name Date

_____

Signature of Patient / Responsible Party Date