Eric Chatterley, DDS
9299 S. Broadway, Suite 200
Highlands Ranch, CO 80129

Patient Information for Chatterley Family Dentistry

Patient Name: _____

Gender: ____Male _____Female Family Status: ___Married ___Single ___Child ___Other
Birthdate: _____ SS#_____
E-mail Address: _____
Phone: (___)_____ (____)_____ (____)_____
Home Cell Work
Address: _____
_____
City State Zip Code

Whom may we thank for referring you to our practice?

_____Former Patient _____Insurance list _____Referral from another office

_____Friend _____Location _____Facebook _____Internet

Name of person or source referring you to our practice: _____

Responsible Party Information (mark same for this section if information is above)
Name: _____
Birth date: _____ Email address _____
Phone: (___)_____(___)_____(___)_____
Home Cell Work
Address: _____
_____
City State Zip Code

Employment Information
Information for: _____Patient _____Person responsible for payment
Employer name: _____
Address: _____
_____
City State Zip Code
Employer Phone Number:
(_____)_____

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Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and/or alternative benefits given, you will be responsible for paying the full balance amount remaining on the account at that time. Our office will make an attempt to appeal any claim that we feel is incorrect. We will provide the necessary documentation your insurance company requests to settle the claim. If your insurance company has not made payment within 30 days of billing, the balance will become your responsibility. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____

Insured's Birth date: _____ ID #: _____ Group # _____

Subscriber #_____Insured SS#:_____

Patient's relationship to insured: ____Self ____Spouse ____Child ____Other

Insurance Plan Name: _____

Insurance Address: _____

_____

City State Zip Code

Insurance Phone Number: (___)_____

Secondary Dental Insurance:

Name of Insured: _____

Insured's Birth date: _____ ID #: _____ Group # _____

Subscriber #_____Insured SS#:_____

Insured's Address: _____

_____

City State Zip Code

Insured's Employer's Name: _____

Employer Address: _____

Patient's relationship to insured: ____Self ____Spouse ____Child ____Other

Insurance Plan Name: _____

Insurance Address: _____

_____

City State Zip Code

Insurance Phone Number: (___)_____

HEALTH HISTORY FORM for Chatterley Family Dentistry

PATIENT NAME _____ **BIRTH DATE** _____/_____/_____

DENTAL INFORMATION

Approximate date of last dental check-up _____

How many sodas, sports drinks, or juices do you consume in a day on average? _____

Please check if you have any of these concerns:

- ☐ Nervous about dental treatment
- ☐ Tooth pain (scale of 1-10 _____)
- ☐ Sensitivity
- ☐ Jaw pain
- ☐ Mouth sores
- ☐ History of periodontal treatment/deep cleaning
- ☐ Clench/Grind teeth
- ☐ Appearance of teeth
- ☐ Bite issues
- ☐ Bad breath

ALLERGIES:

- ☐ Penicillin
- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Sulfa
- ☐ Other:

_____

_____

_____

Please list current medications and doses (including over-the-counter and any birth control)

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY

Height_____ Weight_____

Women: Pregnant or anticipate becoming pregnant Y / N

Physician: Name_____ Phone #_____ Pharmacy_____

Please check if you have any of the following:

Cancer
- ☐ Cancer surgery
- ☐ Chemotherapy
- ☐ Radiation

Cardiovascular
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Stroke/TIA
- ☐ Heart surgery
- ☐ Valve replacement
- ☐ Heart failure
- ☐ Heart murmur
- ☐ Other: _____

Drug Use
- ☐ Tobacco
- ☐ Alcohol abuse
- ☐ Chemical dependency (narcotics)
- ☐ Recreational drugs

Endocrine/Hepatic
- ☐ Diabetes: (circle type: I II)
- ☐ Thyroid disease/problem
- ☐ Liver disease/problem
- ☐ Jaundice
- ☐ Hepatitis: (circle: A B C)

Eyes/Ears
- ☐ Glaucoma
- ☐ Impaired vision
- ☐ Impaired hearing

Gastrointestinal
- ☐ Acid Reflux/GERD
- ☐ Irritable bowel syndrome
- ☐ Stomach ulcers

Hematologic
- ☐ Anemia
- ☐ Sickle cell disease
- ☐ Abnormal/excessive bleeding

Immunologic/Rheumatologic
- ☐ Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome

Infections
- ☐ HIV/AIDS
- ☐ STD's/HPV
- ☐ Cold sores/Oral Herpes
- ☐ Tuberculosis
- ☐ Chicken Pox/Shingles

Mental Health
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Eating disorder
- ☐ Sleep disorder/Insomnia
- ☐ PTSD/Trauma

Musculoskeletal
- ☐ Artificial joint
- ☐ Fibromyalgia
- ☐ Osteoporosis/Osteopenia
- ☐ Bisphosphonate use

Neurologic
- ☐ Epilepsy/seizures
- ☐ Migraines
- ☐ Parkinson's disease
- ☐ Multiple Sclerosis
- ☐ Alzheimer's/Dementia
- ☐ Autism Spectrum Disorder
- ☐ ADD/ADHD

Renal
- ☐ Dialysis
- ☐ Kidney disorder

Respiratory
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Sleep apnea
- ☐ Difficulty breathing

Skin
- ☐ Hives
- ☐ Other skin lesions/tumors

Please list any other medical concerns not listed and history of surgeries:

_____

_____

_____

_____

_____

I authorize that all the information on this form is true and correct.
I give my permission for the doctor to do all diagnostics and x-rays as required for my treatment.

Signature of Patient/Guardian _____ **Date** _____/_____/_____

NOTICE OF PRIVACY PRACTICES

Dr. Eric Chatterley D.D.S.
Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

The office/hospital is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- An assistant or hygienist or dentist obtains treatment information about you and records it in a health record.
- During the course of your treatment, the dentist determines if he will need to consult with another specialist in the area. He will share the information with such specialist and obtain his/her input.

Example of Use of Your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office -- we are not required to grant the request, but we will comply with any request granted;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for the office;
  - Is not part of the information that you would be permitted to inspect and copy; or,
  - Is accurate and complete.

  If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office/, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact Kimberly Bradley or Melissa Hadden, in person or in writing, during regular, business hours. She will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact us. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Kimberly Bradley. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services, whose street address and e-mail address is: Office for Civil Rights - U.S. Department of Health and Human Services - 200 Independence Avenue S.W. - Room 509F, HHH Building - Washington, D.C. 20201.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

ACKNOWLEDGMENT OF PRIVACY

Name of Practice: Eric S. Chatterley DDS, PC

_____ _____

Name of Patient (please print) **Date of Birth**

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received Dr. Chatterley's Notice of Privacy Practices.

_____ _____

Signature of Patient or Patient Representative **Date**

ACKNOWLEDGMENT OF FINANCIAL AND CANCELLATION POLICY

We are committed to providing excellent care for our patients. We typically schedule more time than most dental offices for dental appointments. It can be difficult to reschedule appointments when we have little notice. We request that you give us at least **48 hours** notice if you must reschedule your appointment. There may be a **$75 fee** for appointments missed with less than **48 hours notice or no communication.**

Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time.

Our office will make an attempt to appeal any claim that we feel is incorrect. We will provide the necessary documentation your insurance company requests to settle the claim. If your insurance company has not made payment within 30 days of billing, the balance will become your responsibility.

Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.

_____ _____

Signature of Patient or Patient Representative **Date**