TIME 01:19 PM DATE 10/24/2018

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency contact ph

Emergency Contact

Referral Source

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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, c

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	
Do you use controlled substances?	Yes No	If yes

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

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

Have you ever had any serious illness not listed above? 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:_____

Authorization to Call or Leave Messages

In accordance with HIPAA regulations, we are requesting, in writing, the best phone number(s) and/or e-mail we may use to contact you and/or to leave a message. Most calls will be regarding scheduling, however, on occasion we may call regarding your oral health or your account.

Please provide only those phone numbers and e-mail that we have permission to leave sensitive information.

(Please print clearly—Thank you)

Patient Name: _____

Parent/Guardian/Personal Agent: _____
(For patients under the age of 18)

Home #: _____ Work #: _____
Cell #: _____ E-mail: _____
The best way to reach me in case of last-minute scheduling changes or other reasons:
( ) Home; ( ) Work; ( ) Cell; ( ) e-mail *(check all that apply)*

Patient's Authorization to Release Information
I, _____, authorize **Dr. Evanson and staff**
to share and/or release dental information to _____ .

Relationship: _____ Home #: _____
Work #: _____ Cell #: _____

I understand that I may remove this authorization at any time in writing.
Signature of Patient:_____ **Date**:_____
Parent or Guardian Signature _____ **Date**_____

This authorization will be kept in your chart for future reference. No changes will be made unless authorized by you in writing. If you wish to make any changes please request another form. Thank you.

HIPAA Acknowledgment Form

You have the right to complain to us and to the Secretary of the U.S. Department of Health and Human Services (HHS) if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.

For more information or to file a complaint with us, contact our Privacy Officer by phone or mail as follows: Dr. Angela Evanson. To file a complaint with the Secretary of HHS, send your complaint to:

REGIONAL OFFICE OF CIVIL RIGHTS
999 18th St #417
Denver, CO 80202

If you have any questions or want more information about this Notice of Privacy Practices, please contact our Privacy Officer, Dr. Angela Evanson.

Acknowledgement of our Notice of Privacy Practices for Dr. Angela Evanson, LLC…

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at 17167 E. Cedar Gulch Pkwy, #202, Parker, CO 80134, to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.
Print Name:_____

Signature: _____ _____ **Date**: _____
Signature of Patient or Guardian

Name:_____

Angela S. Evanson, D.D.S., P.C.
Terms and Conditions

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. Please initial the following provisions indicating that you understand our terms and conditions.

_____ I understand, as a courtesy to me, Dr. Evanson will complete insurance information forms and submit claims on my behalf to my insurance company; however I will not hold Dr. Evanson responsible for the outcome of the transactions.
_____ I agree to sign any necessary assignment documents that may be required by my insurance company that instructs my insurance company to make payments directly to Dr. Evanson.
_____ I agree to pay the estimated copayment, which is the amount not covered by my insurance company, at the time of service. (The copayment is only an **estimate** of charges and may be found to be insufficient after reviewed by the insurance company).
_____ I agree to submit payment in full if my insurance company does not pay within 60 days from date of service and therefore I will be responsible for seeking reimbursement from the insurance company.
_____ I understand that if my insurance company denies any or part of the service performed, I will be responsible for paying the balance.
_____I understand that Dr. Evanson will not dispute any outstanding claims with my insurance company on my behalf. It will be my responsibility to resolve any type of dispute over payments made or not made by my insurance company.
_____I understand that predetermined rates are NOT a guarantee of payment by my insurance company.

In addition to the provisions regarding my insurance I also agree to the following terms set forth by Dr. Angela Evanson:
_____I understand that I will provide at least 48 hours notice to change my appointment otherwise it will be considered a missed appointment and is subject to a missed appointment fee.
_____I understand that I will be required to pre-pay a deposit to schedule an appointment if I miss 2 or more appointment in a 12-month span.
_____I understand that a service charge of 1.5% per month will be charged on unpaid balances for all accounts exceeding 60 days unless written financial arrangements are made.
_____I understand that my account may be turned over to a collection agency for non-payment or delinquency. I will be responsible for payment of any and all collection costs, attorney fees, and the balance owed. All accounts turned over to a collection agency forfeits any past special fees or discounts.
_____I understand that there is an "After-hours" fee for any emergencies that are required after normal working hours.
_____I understand that any controlled substance drug (ie: Valium) prescribed to me will place my name on Prescription Drug Monitoring Program or PDMP.

I have read and understand the terms and conditions set by the office of Dr. Angela Evanson

Patient's name (please print): _____

Patient signature_____ Date: _____

Parent or Guardian: _____

17167 E. Cedar Gulch Parkway, Suite 202
Parker, Colorado 80134
303-805-9999
FAX 720-500-6076
WEBSITE www.evansondds.com

AUTHORIZATION TO RELEASE DENTAL RECORDS

Dental Office:_____
Address_____
_____
Phone:_____
Email:_____
Fax:_____

I,_____
(Print Name) (Date of Birth)

Authorize and request my dental records/x-rays to be released to:

Angela Evanson, DDS
17167 E. Cedar Gulch Pkwy.
Suite 202
Parker, CO 80134
Fax: 720-500-6076

You may email digital records to: **info@evansondds.com**

_____
(Patient/Guardian Signature)