Welcome to Mountain Vista Dental

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First M Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First M

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Secondary Dental Insurance

Name of Insured: _____ _____ ___
Last First M

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ Allergy Amoxicillin
- ☐ Allergy Keflex
- ☐ Allergy to Codeine
- ☐ Allergy/ Anesthetics
- ☐ Artifical Heart valv
- ☐ Cancer
- ☐ COVID 19 Vaccine
- ☐ Frequent Headaches
- ☐ Heart Disease
- ☐ Hepatitis A/B/C
- ☐ HIV/AIDS
- ☐ Low Blood pressure
- ☐ Pre-Diabetes
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Allergy Clindamycin
- ☐ Allergy Penicillin
- ☐ Allergy to Iodine
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Colitis
- ☐ Currently Pregnant
- ☐ G.E.R.D.
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Hx of Blood Clots
- ☐ Mental Health Issue
- ☐ Radiation Treatment
- ☐ Sjogren's Syndrome
- ☐ Take Premed for TX
- ☐ Tuberculosis
- ☐ Allergy Doxycycline
- ☐ Allergy Tetracycline
- ☐ Allergy to Latex
- ☐ Anticoagulant Tx
- ☐ Asthma
- ☐ COPD
- ☐ Diabetes
- ☐ Head Injuries
- ☐ Heart surgery
- ☐ High BP Med
- ☐ Kidney Problems
- ☐ Osteoporosis
- ☐ Respiratory Problems
- ☐ Sleep Apnea/CPAP
- ☐ Tapazole
- ☐ Vertigo
- ☐ Allergy Erythromycin
- ☐ Allergy to Aspirin
- ☐ Allergy to Sulfa
- ☐ Arthritis
- ☐ Blood Disease
- ☐ COVID 19
- ☐ Epilepsy
- ☐ Heart attack/TIA
- ☐ HeartBurn/AcidReflux
- ☐ High cholestrol
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Smoker
- ☐ Teeth Sensitivity

- ☐ Ever been hospitalized (illness or injury)
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Subject to frequent headaches
- ☐ FEMALE: Taking birth control pills
- ☐ Presently being treated for any other illnesses
- ☐ Taking dietary supplements
- ☐ A smoker or smoked previously
- ☐ FEMALE: Pregnant

If any condition or alerts selected above needs further clarification, please explain below:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

Name of physician and their specialty:

_____

_____

Most recent physical exam and purpose:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

_____

_____

List all medications, supplements, and/or vitamins taken within the last two years:

_____

_____

☐ *By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long you have been a patient there:

_____

_____

Date of most recent dental exam: _____ **Date of most recent dental x-rays:** _____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Personal History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had trouble getting numb
☐ Had/have braces, orthodontic treatment
☐ Had any teeth removed
☐ Had complications from past dental treatment
☐ Had any reactions to local anesthetic
☐ Had your bite adjusted

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ *By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the HIPAA Disclosure Form.

Consent for Internet Communications

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ *I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Consent for Treatment

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

☐ *By checking this box, I understand the above information and agree with its contents.

Patient Contact Consent

I understand that I have certain rights regarding my protected health information. I understand that these rights are given to me under the Health Portability and Accountability Act of 1996 (HIPAA). In caring for our patients, it may be necessary for Mountain Vista Dental to contact you by telephone, when you are not available to speak directly. We will leave a message when possible.

Please review the information below and consider carefully how and whom you choose to have access to your medical information, scheduling information about an upcoming procedure and inquiries about your insurance or billing information.

Please check ONE of the following options below:

☐ I DO NOT authorize Mountain Vista Dental to leave a detailed message with any person, leave a voice mail or an e-mail.

☐ I DO authorize Mountain Vista Dental to all of the following checked options below in regards to my personal information and how I wish to be contacted.

IF YES, DO AUTHORIZE please check all applicable ways for us to reach you or leave a message for you below:

☐ Cellphone call or voice mail (detailed message)

☐ Home phone call or voice mail (detailed message)

☐ Office phone call or voice mail (detailed message)

☐ Email:_____

☐ Spouse (detailed message)

☐ Other family member or friends (detailed message) Please List:_____

I have the option to update and/or change my preferences of how you contact me at any times by completing a new patient contact consent form otherwise putting my request in writing and submitting it to Mountain Vista Dental.

Mountain Vista Dental
Financial Responsibility Agreement

Please read and initial each blank and sign full name in both places at the bottom.

This is a legally-binding agreement between Mountain Vista Dental and you as the patient. It describes your financial obligations. You Must read this, initial all blanks, sign it and return it to us prior to your first treatment. The term "MVD" means Mountain Vista Dental. The terms "I", "my", "you", or "your" , all refer to the patient.

MVD is committed to give you the best care. In return I agree to be financially responsible for payment of Mountain Vista Dental's services.

Acceptable forms of payment are: 1.) CASH OR PERSONAL CHECK. 2.) VISA, MASTERCARD, OR DISCOVER. This allows you to make as many payments as you wish to your personal credit card company. 3.) A 3 MONTH PAYMENT PLAN. After 90 days a 1.5% per month (18% APR) interest charge will be assessed. If more than 3 months is required for payment, the office has a financing program (CARE CREDIT) that has no interest plans up to 18 months.

As a courtesy in our office, we will file your insurance claim for you and try to assist in any way that we can. Dental insurance is a contract between you, your employer, and your insurance company. Insurance benefits are determined by the insurance company and not by our office. We file over 4000 dental plans; therefore, it is impossible for us to know the specifics of each one. IT IS THE PATIENTS RESPONSIBILITY TO KNOW THE DETAILS OF YOUR POLICY, ESCPECIALLY WETHER OR NOT YOU CAN USE US AS A DENTAL PROVIDER. THIS CAN BE DONE BY CALLING YOUR INSURANCE COMPANY DIRECTLY OR CONTACTING YOUR HUMAN RESOURCE DEPARTMENT AT YOUR PLACE OF EMPLOYMENT. FINALLY, ALL DENTAL INSURANCE POLICIESHAVE A MAXIMUM THAT THEY WILL PAY OUT PERYEAR ON AN INDIVIDUAL. THIS CAN BE ANY WHERE FROM 750 TO 2000. PLEASE BE AWARE OF YOUR POLICY.

I agree to be responsible for payment of MVD's services, regardless of whether the services are covered by insurance and regardless of the extent of payment, if any, by my insurance. I agree to pay any balance remaining on my account for any reason after my insurance has been processed. I agree that if MVD has not received payment within forty-five (45days) of the original filing, I will be responsible for the entire account.

INITIAL: _____

I agree to give MVD complete and accurate insurance information for primary and secondary coverage and all identification and benefit cards/documents required for claim accuracy. I understand that failure to supply complete and accurate information may result in denial of claim or delay payment. I agree to pay any balance remaining on my account for any reason after my insurance has been processed.

INITIAL: _____

I understand that my insurance may or may not agree with the UCR (usual, customary, and reasonable) charges for local area and my benefit plan may not cover all services or may even deny payment for services hat have been authorized in advance. I agree to pay any balance remaining on my account for any reason after my insurance has been processed. I UNDERSTAND THAT AN INTEREST CHARGE OF 1.5% PER MONTH (18%APR) WILL BE CHARGED ON ANY UNPAID BALANCE OVER 90 DAYS OLD.

INITIAL: _____

I understand that any invoice or receipt issued by MVD at the time of service is a NON-BINDING ESTIMATE ONLY and ADDITIONAL CHARGES my apply depending upon the services rendered. I agree to pay any balance remaining on my account for any reason upon receipt of a statement.

INITIAL: _____

If you prefer to have "exact" benefit information for your insurance company, we suggest sending a written preauthorization to the insurance company and wait for the written results before scheduling your appointment for treatment. If I choose to proceed with recommended treatment before a written preauthorization is received from my insurance company, I know that I am responsible for any balance on my account for any reason after my insurance has been processed.

INITIAL: _____

I understand that if my account is sent to collection agency, I will be charged collection fees tat can be 100% of my overdue balance.

INITIAL: _____

I hereby authorize direct payment of dental insurance benefits to MVD. This authorization will remain in effect until revoked by me in writing. A copy of the authorization is as valid as the original.

INITIAL: _____

I understand that if I cancel my appointment without a 48-hour notice, there will be a charge.

INITIAL: _____

☐ * **BY CHECKING THIS BOX, I ACKNOWLEDGE AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, SURCHARGES, LATE FEES, BILLING FEE, INTEREST, ATTORNEY FEES/AND COLLECTION AGENCY CHARGES, WEHATHER OR NOT THEY ARE PAID BY MY INSURANCE.**

Print Patient Name_____

Signature _____ **Date** _____

Response Date: _____