Swankhouse Dental

363 S. Harlan St. Ste 110 | Lakewood CO 80226 | (303)935-6559 | swankhousedental.com

Welcome to our office! To assist us in treating you, please complete the following confidential form. The information provided is necessary to your dental health.

Patient's Name _____ Preferred Name _____ DOB _____

Street Address _____ Unit # _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Okay to text? □Yes □No

Employer _____ Occupation _____ SSN _____

Email Address: _____ How did you hear about us?_____

Billing and Insurance Information

Subscriber: □Spouse □Self □Both □No Insurance □Dual Insurance

Primary Dental Insurance _____ Subscriber's Name_____

Subscriber ID # _____ Subscriber SSN _____ Subscriber DOB_____

Medical Health History

Do you have or have you had any of the following? (please check all that apply)

□Heart Problems
- □Chest Pain
- □Shortness of Breath
- □High Blood Pressure
- □Low Blood Pressure
- □Heart Murmur
- □Heart Valve Problem
- □Rheumatic Fever
- □Pacemaker
- □Artificial Heart Valve

□Intestinal Problems
- □Ulcers
- □Weight Gain or Loss
- □Kidney or Bladder Problems

□Diabetes
- □Type 1 □Type 2

□Tuberculosis or other Respiratory Disease
□Herpes or other STD
□Fainting, Seizures, or Epilepsy
□Frequent or Severe Headaches
□Premedication required by Physician
□Nervousness

□Blood Problems
- □Easy Bruising
- □Frequent Nosebleeds

□Abnormal Bleeding
- □Blood Disease (Anemia, etc.)
- □Blood Transfusion

□Allergy Problems
- □Hay Fever
- □Sinus Problems
- □Skin Rashes

□Asthma
□Bone or Joint Problems
- □Arthritis
- □Joint Replacement
  Which Joint and Year_____

□Hepatitis, Jaundice or Liver Trouble
□HIV or AIDS
□Stroke
□Thyroid Problems
□Cancer or Tumor
□Sleep Apnea, if so do you use a CPAP? _____
□Jaw Pain

Do you have any allergies or adverse reactions to medications, anesthetics or latex? _____

If so, please list the name and reactions_____

Women: Are you pregnant, think you are pregnant, or nursing? _____

Do you drink alcohol? If so, how much and how often? _____

Do you smoke? If so, how much and for how long? _____

Any history of drug or alcohol abuse? _____

Please list the name and phone number of your primary care doctor. _____

Please list all medications and/or supplements that you are taking.

Name of drug	Dosage	Reason for medication

Do you have any disease, condition or problem not listed above? _____

Have you ever been told that you snore? _____ Do you experience daytime sleepiness or tiredness? _____
Do you usually sleep through the night? _____ Have you ever woken suddenly with shortness of breath, gasping or with your heart racing? _____

I hereby attest that all the information provided above is true to the best of my knowledge.

_____

Patient Signature Patient Printed Name Date

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General Consent

I, _____, consent to be a patient at Swankhouse Dental and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canal treatment), fixed and removable prosthodontics (crowns, bridges and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry and radiography.
2. I authorize Dr. Swankhouse to prescribe and/or administer any drugs, medicaments, antibiotics, and local anesthetics necessary or appropriate in my care.
3. I will provide a thorough and complete medical history, supply a full list of my medications with dosages and consent to Dr. Swankhouse communicating with my other medical practitioners to inquire about any aspect of my health history.
4. No guarantees can be made about treatment outcomes, restoration longevity or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
5. I will pay in full any cost of treatment or insurance copayment according the the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am inevitably responsible for any and all fees. Although the office will try to best estimate how my insurance company will pay, each plan is different and it is possible that insurance companies will not pay as expected or not pay at all, thereby leaving myself with a balance that will need to be paid in full
6. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with the dental staff.
7. I am welcome to ask questions about any aspect of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspect of my treatment that I am unsure about.

_____ _____

Patient or Legal Guardian Signature Date

_____ _____

Witness Date

Cancellation/ Missed Appointment Policy

Our goal at Swankhouse Dental is to provide quality dental care in a timely manner. In order to do so, we have implemented an appointment/ cancellation policy. This policy enables us to better utilize available appointments for our patients in need of dental care.

Cancellation of an Appointment:

In order to be respectful of the needs of our patients, please be courteous and call Swankhouse Dental if you are unable to attend your appointment. This time will be reallocated to someone who is in need of treatment that day. If it is necessary to cancel your scheduled appointment, we require that you call at least 48 hours in advance. Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care.

How to Cancel Your Appointment:

To cancel appointments, please call Swankhouse Dental at (303)935-6559 at least 48 hours prior to your scheduled appointment. If you do not reach the staff, you may leave a detailed message on the voicemail. If you would like to reschedule your appointment, please be sure to leave us your phone number and we will return your call as soon as possible. Late cancellations will be considered as a “no-show”.

No-show policy:

A “no-show” is either arriving more than 15 minutes late for a scheduled appointment or a missed appointment without 48 hours notice. “No-shows” inconvenience other patients who may need access to care in a timely manner. A failure to present at the time of a scheduled appointment without adequate notice will be recorded in the patient’s chart as a “no-show” and a $75 per hour of appointment time missed will be assessed and must be paid prior to your next appointment. Any further “no-show” appointments may result in the termination of the patient from the practice.

We may provide a courtesy appointment reminder, however, you are responsible for keeping the appointments that you make. How do you wish we contact you for appointment reminders?

- ❑ Text _____
- ❑ Call _____
- ❑ Email _____

I have read the above policy completely. I agree to all of the terms and understand that if I violate this policy, it may result in the termination of my doctor/ patient relationship.

_____ _____

Patient Signature Date

Barbara D. Swankhouse DDS, PC
dba Swankhouse Dental
FINANCIAL POLICY

Swankhouse Dental believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card or license due to the many cases of identity theft in the news lately. (Please do not be offended!)
2. INSURANCE We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.
3. If our doctor is not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff can not guarantee your eligibility and coverage. Be sure to check with you insurer's member benefits department about services and providers before your appointment. Many websites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.
4. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.
5. Patients who insist on "day of" urgent/emergent scheduling or care after hours or on days the clinic is closed will be assessed an additional urgent care or after hours fee. These fees will be billed to your insurance carrier or collected as part of the office charges for self pay patients.
6. LATE CHARGES of 12% annually will be applied to all patient balances 90 days old or greater.
7. RETURNED CHECKS will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Jefferson County.
8. ACCOUNTING PRINCIPALS Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.
9. FORMS FEES Completing insurance forms, copying medical records, etc... requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges

are $10 per occurrence plus and applicable postage or notary fees. Postage is additional and payment is required in advance. Copying fees for Medical Records is $10 for the first twenty (20) pages and $0.50 per page in excess of twenty. Barbara D. Swankhouse DDS PC, will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed the form authorizing records' release.

10. BILLING OFFICE: If you have questions in regard to any of your billing statements, our staff is available to assist you. CALL (303)935-6559
11. RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to Swankhouse Dental for charges not covered by the assignment of insurance benefits.
12. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, transfer, and set over directly to Barbara D. Swankhouse DDS PC sufficient monies and/or benefits for basic and major dental to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize Barbara D. Swankhouse DDS PC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or plan administrator to release such information to Barbara D. Swankhouse DDS PC. I authorize Barbara D. Swankhouse DDS PC to release all dental/medical information requested by my insurance carrier, other physicians or providers, and any other third-party payers.
13. RELEASE OF INFORMATION: I hereby authorize and direct Barbara D. Swankhouse DDS PC to release to governmental agencies, insurance carriers, or others who are financially liable for dental/medical care, all information needed to substantiate claim and payment.
14. COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.
15. DIVORCED PARENTS of MINOR PATIENTS: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

Printed Name of Patient_____

Swankhouse Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form will be retained in your dental record.

By my signature below, I _____, acknowledge that I have **received** a copy of the Notice of Privacy Practices for Swankhouse Dental.

I hereby designate the following individual(s) to receive communications from Swankhouse Dental that may include dental/medical information about me:

_____

_____ _____

Signature of patient (or personal representative) Date

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

I authorize Swankhouse Dental to leave voice mail messages concerning my health information (i.e., lab results, appointment instructions, etc.) at the following number:

Phone( )_____(Patient initials)_____

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ **Individual refused to sign**
- ❑ **Communications barriers prohibited obtaining the acknowledgement**
- ❑ **An emergency situation prevented us from obtaining acknowledgement**
- ❑ **Other (Please Specify)**

_____ _____

Employee Name **Date**