ENGELHARDT & ASSOCIATES
family dentistry

Welcome to our practice! We thank you for making us your choice and joining with us in caring for your dental health. By becoming our patient, we create a partnership which we hope will last through the years.

Our office is prevention oriented and is dedicated to your health. We are committed to providing superior dental care and are proud of our dedication to our patients. Our goal is to help you feel and look your best while focusing on long-term dental health.

Our office hours are patient oriented and we are available for emergency services. Because communication is important, we will advise you of treatment needs and expenses in advance. We are an out-of-network provider, but we are happy to assist with your insurance filing. We are here to serve you, so please do not hesitate to contact us regarding any matter.

At your first visit, we will take the time to get acquainted with you and discuss your dental needs and desires. We will perform a comprehensive dental evaluation and gather information to make a customized treatment plan for you.

Following are the forms that we will need on or before your first appointment.

- New Patient Information Packet – please fill out the entire packet prior and bring with you to your first appointment. In addition please bring a list of medications and supplements you are currently taking
- Release of Records – please fill out and return to our office as soon as possible so that we have sufficient time to request x-rays and records from your previous dental office
- Please bring your dental insurance card or a copy (if applicable)
- Medication List (if applicable)

We welcome new patients and appreciate any referrals we might earn. Again, we welcome you and look forward to a long and healthy partnership with you, your family and friends.

Best regards,

Dr. Geoff Engelhardt
Dr. Raechel Nelson

Geoff R. Engelhardt, DDS
1136 East Stuart Street, Bldg 4, Suite 104 • Fort Collins, Colorado 80525
(970) 484-4890
DrGeoffDDS.com

PATIENT INFORMATION

Name_____ **Date** _____

Address_____**City**_____**State**_____**Zip**_____

Gender M ☐ F ☐ Age_____ **D.O.B.**_____ **Social Security No./ID No.**_____

Parent's Name (if minor)_____ **Preferred Pharmacy**_____

Employer _____ **Referred by** _____

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

Name_____

Address_____**City**_____**State**_____**Zip**_____

Home Phone _____ **Work Phone**_____ **Cell Phone**_____

Employer _____ **RELATIONSHIP TO PATIENT** _____

DENTAL INSURANCE INFORMATION

Subscriber Name_____ **Subscriber Social Security No./ID No.**_____

D.O.B._____ **Employer**_____ **Insurance Company** _____

Group/Plan No._____ **Do you have dual coverage? ☐Yes ☐No If yes, please indicate secondary insurance information** _____

PHONE NUMBERS AND CONTACTS

Home Phone _____ **Work Phone** _____ **Cell Phone**_____

Best number to be reached at: _____ **E-Mail** _____

*** We will be contacting you by mail, e-mail, and phone (call/text) regarding appointments, reminders, questions, or concerns.**

EMERGENCY CONTACT

Name _____ **Relationship** _____

BEST NUMBER to reach your contact in the event of an emergency_____

DENTAL/HEALTH HISTORY

Reason for today's visit_____

Former Dentist_____ **City/State**_____ **Date of last visit**_____

Date of last dental x-rays_____ **Any PRE-MEDICATION needed?**_____

Are you interested in teeth whitening? ☐Yes ☐No What would you like to change about your smile? _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐Yes ☐No	Bleeding gums	☐Yes ☐No	Blisters on lips/mouth	☐Yes ☐No
Dry mouth	☐Yes ☐No	Fingernail biting	☐Yes ☐No	Chew on one side of mouth	☐Yes ☐No
Grinding teeth	☐Yes ☐No	Swollen gums	☐Yes ☐No	Burning sensation on tongue	☐Yes ☐No
Ear pain	☐Yes ☐No	Sensitivity to heat	☐Yes ☐No	Food collection between teeth	☐Yes ☐No
Piercing	☐Yes ☐No	Sensitivity to cold	☐Yes ☐No	Loose teeth or broken fillings	☐Yes ☐No
Sensitivity when biting	☐Yes ☐No	Sensitivity to sweets	☐Yes ☐No	Sores/growths in your mouth	☐Yes ☐No
Jaw pain/clicking	☐Yes ☐No	Mouth pain, brushing	☐Yes ☐No	Periodontal treatment	☐Yes ☐No
Alcohol Consumption	☐Yes ☐No	Mouth breathing	☐Yes ☐No	Orthodontic treatment	☐Yes ☐No
Frequency _____		Tobacco use	☐Yes ☐No	Drugs (recreational/medicinal)	☐Yes ☐No

HEALTH HISTORY

Have you ever taken any of the group of drugs collectively referred to as "bisphosphonates"? These are used to INCREASE BONE DENSITY. These include, but are not limited to, oral forms such as Actonel (risedronate), Boniva (ibandronate), Fosamax/ Plus D (alendronate), Skelid (tiludronate), Didronel (etidronate), or I.V. forms such as Aredia (pamidronate), Zometa (zolendronic acid), Bonefos (clodronate). ☐Yes ☐No

Are you currently taking **blood thinners** (Coumadin, Warfarin, or Aspirin)? ☐Yes ☐No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Dementia	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Alzheimer's	☐Yes ☐No	Diabetes	☐Yes ☐No	Parkinson's	☐Yes ☐No
Anemia	☐Yes ☐No	Emphysema	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Arthritis/Rheumatism	☐Yes ☐No	Epilepsy	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Fainting/dizziness	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Glaucoma	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Asthma	☐Yes ☐No	Headaches	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Back Problems	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Bleeding abnormally, with		Heart Problems	☐Yes ☐No	Skin Rash	☐Yes ☐No
Extractions or surgery	☐Yes ☐No	Herpes	☐Yes ☐No	Sleep Apnea	☐Yes ☐No
Blood Disease	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Special Diet	☐Yes ☐No
Cancer	☐Yes ☐No	HPV Infection	☐Yes ☐No	Stroke	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Jaundice	☐Yes ☐No	Swollen Feet or Ankles	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Jaw Pain	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Cochlear Implant	☐Yes ☐No	Liver Disease	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Congenital Heart Lesions	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Cortisone Treatments	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Tumor or growth on	
Cough, persistent/bloody	☐Yes ☐No	Nervous Problems	☐Yes ☐No	Head or neck	☐Yes ☐No
Contact lenses?	☐Yes ☐No	Pacemaker	☐Yes ☐No	Ulcer	☐Yes ☐No
Women:	Are you taking birth control pills? ☐Yes ☐No			Venereal Disease	☐Yes ☐No
	Are you nursing? ☐Yes ☐No			Weight loss, unexplained	☐Yes ☐No
	Are you pregnant? ☐Yes ☐No		*If so,* Due Date_____		

MEDICATIONS, VITAMINS, AND SUPPLEMENTS

List any medications, vitamins, & supplements you are taking and the correlating diagnosis, dosage, and strength:

_____

_____

_____

_____

ALLERGIES

Please list any allergies you have especially any drug related allergies:

_____

_____

_____

_____

To the best of my knowledge, all of the preceding answers are correct.

I authorize Geoff Engelhardt DDS PC, Associates, and Team Members to perform any necessary services needed during my diagnosis and treatment and grant permission for them to contact the listed emergency contact if necessary.

Patient Signature_____ Date_____

Doctor's Signature_____ Date_____

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NOTICE OF PRIVACY PRACTICES

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 Health Insurance Portability & Accountability Act of 1196 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may need to use/disclose your medical records only for the following purposes: treatment, payment, health care operations, appointment reminders, disaster relief, and public benefit.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.
- **Appointment Reminders** such as voicemail messages, postcards, letters, e-mail messages, or text messages
- **Disaster Relief**. We may disclose your information to a public or private entity authorized by law or by its character to assist in disaster relief efforts.
- **Public Benefit**
    - as required by law
    - for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury
    - to report adult abuse, neglect, or domestic violence
    - to health oversight agencies

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand 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 its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private 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.

Patient Name: _____

Permission granted to share your information with the following person/s:

_____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: Initials: Reason:

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Patient Financial Responsibility:

Thank you for choosing Engelhardt & Associates as your dental care provider. We are committed to providing you with the highest quality dental care. We ask that you read and sign this form to acknowledge your understanding of our policies.

- The patient (or patient's guardian if a minor) is ultimately responsible for the payment of his/her treatment and care.
- In order to keep our focus completely on patient care, we do not contract with any insurance company. As a courtesy, we will submit claims to your insurance provider and answer any questions you may have regarding your benefits. You are required to provide us with the most current and updated information about your insurance and will be responsible for any charges incurred if the information provided is not correct or updated. We also recommend that you call your insurance company to see if there are any contractual limitations for your particular plan, as we are an out-of-network provider.
- We are happy to submit your dental treatment plan to your insurance company to obtain a predetermination of benefits. We cannot guarantee the final payment amount from your insurance company.
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service. For your convenience, we accept cash, check, Discover, Visa, Master Card, American Express, and Care Credit.

Patient Authorization:

I authorize Engelhardt & Associates to release dental records and any other information necessary to insurance companies, third party payers, and/or other physicians or dental care entities required to participate in my care.

I authorize assignment of financial benefits directly to Engelhardt & Associates. I understand that I am financially responsible for charges not covered by my insurance provider.

_____ _____

Patient Name Date

_____

Patient Signature

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RECORD RELEASE FORM

I, _____ request the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to / from:

Doctor Name:_____

Phone #:_____ Fax #:_____

Email:_____

Name of Patient:_____ Date of Birth:_____

Records being requested: (**office use only**)

( ) Current radiographs ( ) Dental Health Status ( ) Reports

( ) Diagnostic Casts ( ) Treatment Record ( ) Charts

( ) Health History ( ) Prescription Records ( ) Photos

( ) Other:_____

Patient or Guardian Signature:_____ Date:_____