GLENN
FAMILY DENTISTRY

Contact Information

Full Name: _____ DOB: _____ Married: ___ Single: ___

Preferred Name: _____ Referred by: _____

Social Security: _____ Preferred Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ *please indicate preferred

Name of Employer: _____ Address:_____

Emergency Contact

Name:_____ Phone: _____

Address: _____ City:_____ State: ____ Zip: _____

Communication Preferences

We are committed to protecting the privacy of our patients. We utilize all contact information in a responsible and professional manner. Contact information provided will be used for the following purposes: To open and update patient files, invoice patient accounts, process payments, process claims from insurance companies, send reminders to patients, send informational material about our practice, and when permitted or required by law.

Glenn Family Dentistry may communicate with me regarding clinical information and any/all of the above via the following methods: ____ Texts _____ Voicemail ____Email _____Calls to preferred number

Please list any other person/s we may share clinical and appointment related information with:
Name_____ Relationship_____ Name_____ Relationship_____

Name_____ Relationship_____ Name_____ Relationship_____
*Please note – we will not be able to speak with a spouse or parent of a legal adult child without this information for legal patient privacy.
You can withdraw my consent to electronic communications at any time by calling Glenn Family Dentistry at 303-779-2592 or emailing contact@glennfamilydentistry.com

Insurance Policy Information

Insurance company:_____ Name of Primary Insured: _____ Date of Birth: _____

Member ID: _____ Employer: _____ Insurance company phone: _____

Patient/Guardian Signature: _____ Date: _____

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Thank you for choosing Glenn Family Dentistry as your dental health provider. It is our goal to provide you with the best care possible, to exceed your expectations, and to effectively handle your account. Our office policies apply to *all* patients and are necessary in order to provide fair and equal treatment. We are happy to answer any questions you may have regarding these policies at any time.

Insurance and Payment Policies

- **Payment for dental service is expected when treatment is rendered**. You will be informed of your payment or co-payment responsibility at the time treatment is completed so that you may make payment at that visit.
- Our office is willing to accept direct payment from your dental plan, Visa, Mastercard, Discover, American Express, Checks, or cash.
- Dental plans in the marketplace today are too numerous and varied to allow us to know the details of all of them. Your particular dental plan may or may not cover the full extent of the costs you incur for your dental treatment.
- **Please review your dental plan carefully to ensure you understand the exclusions and limitations of your plan. If your dental plan does not cover the full cost of treatment, you will be responsible for any difference.**
- Any returned checks will be charged at $25 Fee in addition to the amount of the check.
- A finance charge of 18% applies to all accounts over 30 days.

Cancellation Policy

- Your appointment time is reserved specifically for you. As a courtesy to the Doctors and other scheduled patients, we ask that you keep your appointments and arrive on time.
- If you need to cancel or change your appointment, we request 72-hour notification. However, **a 48-hour notice is required**.
- **Missed or cancelled appointments with less than 48-hour notice will be assessed a minimum of a *$45.00* cancellation fee**
- We understand that there may be circumstances outside your control in which you are unable to provide the required notice. These will be reviewed on an individual basis.

Consent

I certify that I have read and understand the above information. I understand it is my responsibility to ask questions regarding these policies if my understanding is unclear. By signing, I hereby authorize the Doctors and appropriate staff to perform any and all diagnostic and treatment procedures deemed necessary. If I ever have any change in my health or change in my medication, I will inform the office at my next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of any necessary information in pursuit of these claims.

Print Name:_____ Date:_____

Signature: _____

Glenn Family Dentistry, Professional LLC
3600 S. Beeler Street, Suite 120
Denver, CO 80237
Phone: 303-779-2592

PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Milk ☐ Other _____
Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery*	☐	☐	Excessive Bleeding	☐	☐	Chemotherapy	☐	☐	Night Sweats	☐	☐	Cold Sores	☐	☐
Heart Murmur or Defect *	☐	☐	Sickle Cell Disease	☐	☐	Osteoporosis	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Hemophilia	☐	☐	Bisphosphonates	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Methemoglobinemia	☐	☐	Osteonecrosis of Jaw	☐	☐	Renal Dialysis	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Leukemia	☐	☐	Aredia I.V. Reclast I.V.	☐	☐	Thyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder*	☐	☐	Recent Blood Transfusion	☐	☐	Zometa I.V.	☐	☐	Parathyroid Disease	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse *	☐	☐	Swelling of Limbs	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Arthritis/Gout	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Lung Disease	☐	☐	Stomach/Intestinal Disease	☐	☐	Rheumatism	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Breathing Problem	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Shortness of Breath	☐	☐	Recent Weight Loss	☐	☐	Cortisone Medicine	☐	☐	Nervousness	☐	☐
Heart Pace Maker*	☐	☐	Frequent Cough	☐	☐	Frequent Diarrhea	☐	☐	Artificial Joint *	☐	☐	Psychiatric Care	☐	☐
Pulmonary Shunt*	☐	☐	Hay Fever	☐	☐	Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Excessive Thirst	☐	☐	AIDS	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Asthma	☐	☐	Hypoglycemia	☐	☐	HIV Positive	☐	☐	Allergies (Pollen / Dust)	☐	☐
Bacterial Endocarditis*	☐	☐	Bloody Sputum	☐	☐	Liver Disease	☐	☐	Genital Herpes	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Emphysema	☐	☐	Hepatitis A (Infectious)	☐	☐	Drug Addiction/Alcoholism	☐	☐	Need Premedication?	☐	☐
Bruise Easily/Blood Disease	☐	☐	Tuberculosis	☐	☐	Hepatitis B or C	☐	☐	Tattoos/Body Piercing	☐	☐	Ever taken fen-phen?*	☐	☐
Anemia	☐	☐	Cancer	☐	☐	Protease Inhibitor	☐	☐	Sleep Apnea	☐	☐	Cochlear implants?	☐	☐
Coronary Stent*	☐	☐	X-Ray Treatments (Radiation)	☐	☐									

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____
History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

I have received Glenn Family Dentistry's Notice of Privacy Practices written in plain language. The Notice provides uses and disclosures of my protected health information that may be made by Glenn Family Dentistry, my individual rights, and the Glenn Family Dentistry's legal duties with respect to my protected health information.

The Notice includes the following information:

- A statement that Glenn Family Dentistry is required by law to maintain the privacy of protected health information.
- A statement that Glenn Family Dentistry is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that Glenn Family Dentistry is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which Glenn Family Dentistry is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to file a complaint with Glenn Family Dentistry and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that Glenn Family Dentistry is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from Glenn Family Dentistry upon request.

Glenn Family Dentistry reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain Glenn Family Dentistry's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to Patient *(if signed by a personal representative of patient)*: _____

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RELEASE OF RECORDS AUTHORIZATION

Please send my most current bitewing and full mouth radiographs to Glenn Family Dentistry.

Patient Name: _____

Patient Signature: _____ Date: _____

Glenn Family Dentistry
Megan E. Harbaugh, D.D.S.
DeWayne L. Glenn, D.D.S.

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