Aesthetic Dentistry BY DESIGN

KENNETH O. GASPER II, D.D.S., PC

(719) 599-0700

PATIENT INFORMATION

Welcome to our office

*Date:*___________

PATIENT NAME____SSN:_______________D. LIC#:________________
LAST FIRST MI

ADDRESS:____
STREET CITY STATE ZIP CODE

DATE OF BIRTH:____________________ GENDER: M / F STATUS: MARRIED SINGLE ADULT/ MINOR
(PLEASE CIRCLE ONE)

HOME PHONE:____________________ WORK PHONE____________________ CELL PHONE______________________

E-MAIL ADDRESS:____

EMERGENCY CONTACT: (NAME & PHONE #)____

*Whom may we thank for referring you to our office?*____

FINANCIALLY RESPONSIBLE PARTY

LAST NAME:______________________FIRST NAME:_____________________MI:______SSN:_____________________

ADDRESS:____
STREET CITY STATE ZIP CODE

DATE OF BIRTH:____________________RELATIONSHIP TO PATIENT:_____________________________GENDER: M / F

HOME PHONE:______________________WORK PHONE:_____________________CELL PHONE:____________________

E-MAIL ADDRESS:____

EMPLOYER:____

MY PREFERRED METHOD OF PAYMENT: CASH / CHECK / CREDIT CARD V MC DISCOVER

I understand and accept responsibility for all dental services provided.

SIGNATURE:____ DATE:_________________________

INSURANCE INFORMATION

INSURED'S NAME:______________________________________SSN/ID:_______________________DOB:____________

PRIMARY INSURANCE COMPANY:____

INSURED'S EMPLOYER NAME:____

PATIENT RELATIONSHIP TO INSURED:____

By signing below, I authorize release of information regarding my insurance benefits and payment directly to the provider for all insurance benefits otherwise payable to me. I have read and agree to accept and adhere to the Financial and Patient Agreement.

SIGNATURE:____ DATE:_________________________

Time 11:49 AM | Aesthetic Dentistry By Design | Date 5/3/2016

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question	Answer	
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	

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 use controlled substances?	○ Yes ○ No	If yes

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

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
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	○ 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:__________

AESTHETIC DENTISTRY BY DESIGN

8610 Explorer Drive, Suite 315… Colorado Springs, CO 80920

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing our office for your dental care. We are committed to giving you the best care possible. We expect in return that you have the same commitment to your dental and financial responsibility to us. The following is the financial policy for Aesthetic Dentistry by Design, the office of Dr. Kenneth O. Gasper.

Customer Service: If you wish to discuss your account and or to take advantage of our financing option, please contact our billing department at (719) 599-0700. We accept cash, checks or credit cards (Visa, Mastercard and Discover) as payment. Your insurance co-pay is **due at the time of your visit** and all payments must be made **when services are rendered.** Any cost associated with treatment for dependent children is the sole responsibility of the parent present at the appointment. There will be a $50 service charge for returned checks.

Appointments: Please arrive at least 10 minutes prior to your appointment to give yourself plenty of time to update your records or complete paperwork required by your insurance. In order to meet the needs of all our patients, please call us immediately if you must reschedule your appointment so that we can accommodate another patient's needs. If you fail to cancel or reschedule within **24 hours of your dental appointment, you will be billed $50 for that missed appointment. If you are more than 10 minutes late for your scheduled appointment time, your appointment may have to be rescheduled as a courtesy to other patients and our staff.** Failure to be present for 3 scheduled appointments (by either missing or rescheduling without 24 hours notice) may result in termination of your care in our office.

Financing Options & Courtesy Discounts: We offer financing options through Care Credit. We also offer a 5% (five percent) courtesy discount for all treatment that is paid in full at the time of service. When there is insurance involved, we will file this for you as a courtesy and you will receive reimbursement directly from your insurance company should you wish to take advantage of the 5% accounting courtesy. **We are not able to offer this discount with any Delta Dental programs.

Insurance Filing: As a courtesy to our patients, we will file insurance claims with all standard insurance carriers. The patient is responsible to make available to the Practice complete insurance information for accurate filing of claims. It is the patient's responsibility to pay any deductible or co-pay at the time of the visit. **Any unpaid balance including any unpaid insurance balance after 60 days of submission becomes the sole responsibility of the patient.**

Account Balances: All unpaid balances are subject to a 21% APR interest charge. **All accounts over 90 days past due will be referred for collection unless prior arrangements have been made.** Any costs associated with a delinquent account will be added to the outstanding balance.

By signing below, the patient authorizes the exchange of information relating to care and claims with the patient's insurance company(s) and authorizes insurance payments to be made directly to the Practice for services provided under the insurance agreement and otherwise payable to the patient. It is also the patient's responsibility to pay any deductible, co-pay, or any other balance not paid for by the patient's insurance company.

I have read and agree to the Financial Policy and Patient Agreement.

Patient Signature/Responsible Party	Witness Signature	Date

Revised 3/2010

AESTHETIC DENTISTRY BY DESIGN
8610 Explorer Drive, Suite 315
Colorado Springs, CO 80920

719-599 – 0700

Acknowledgement of Receipt of Notice of Privacy Practices

° *You may refuse to sign this acknowledgement*

I have read/received a copy of the offices HIPPA Notice of Privacy Practices.

*Patient Name: (s)*______________________________ *Date:* ________________

____

Patient Signature: ____

(Responsible Party if patient is a minor)

With Regards to Your Care in Our Office, Please indicate how we may contact you:

May we leave a detailed message on your home answering machine? *YES* *NO*

May we speak with your spouse? *YES* *NO*

May we call you at work? *YES* *NO*

Whom else do you authorize us to speak with?
*Name and phone number:*____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not be obtained due to refusal to sign: