NeedDentist.com
P: 970.669.6111 | F: 970.667.6111

Patient Digital Forms

Form Submission Intructions

At **NeedDentist.com** we want your experience as one of our new patients to be as easy and streamlined as possible. Feel free to submit or hand in your forms one of the three following ways:

1. Quick & Easy Digital Submission(*): Simply fill out the Patient Forms below. When finished there is a "**Submit Button**" on page 6. Press the "**Submit Button**", then press "**Send**" from your email client. When you arrive for your scheduled appointment we will have you sign and date the appropriate areas at that time. It's that easy!

2. Fill Out Digitally Now, Print & Sign from Home(*): You may also fill out the Patient Forms now and save them to a desired location. Once done, print them out, sign and date the designated areas, and bring them to the office during your scheduled visit.

3. Print, Fill Out & Hand-In: Feel free to print the Patient Forms out at home, fill them out by hand, and bring them to the office during your schedule appointment.

* IMPORTANT *

To fill out forms digitally on your PC or MAC they must be opened locally with Adobe Acrobat Reader® or comparible PDF viewer. Simply open the file from the downloaded location, or save the file to a desired location and open with PDF Reader.

For Mobile, Search "PDF Viewer" in your app store for compatible software.

For PC or Mac You can **download it here,** if needed. **It's Free!**

DOWNLOAD READER

Patient Information

NeedDentist.com

Date _____

Patient Name _____
Last First Middle

Address _____
Street City State Zip

Phone _____
Home Cell Work

Birthdate _____ Sex M☐ F☐ (check one) Marital Status _____

Employer _____ Occupation _____ Years Employed _____

Guardian Name _____
If patient is a minor

Email Address _____ Referral _____
Whom may we thank for referring you to our office?

Responsible Party Information (if different than above)

Name _____ Date of Birth _____
Last First Middle

Address _____
Street City State Zip

Phone _____
Home Cell Work

Emergency Information

Name of emergency contact not living with you _____

Address _____
Street City State Zip

Phone _____
Home Cell Work

Insurance Assignment of Benefits Agreement

Your insurance information is a contract between you and your insurance carrier. We will glady submit your insurance claim with assignment of benefits to you. If previous arrangements have been made, the Doctor will accept assignment of benefits with your estimated portion due at time of service. After the insurance payment has been received, any outstanding balance will be your responsibility due within 30 days. If there are any questions regarding this process, please contact our office.

_____
Signature of Patient or Guardian Date

_____
Name of Subscriber Subscriber Date of Birth

Subscriber ID No. _____ Subscriber Employer _____
(This could be your social security # or an ID# assigned by the insurance company)

Health History • • •

NeedDentist.com

Patient Name _____

Physicians Name _____

Address _____ Phone Number _____

Have you been hospitalized or received medical treatment in the last year? Yes ☐ No ☐

If yes, explain _____

Are you taking any prescription or non prescription medications? Yes ☐ No ☐

If yes, list them _____

Are you allergic or have you reacted adversely to any of the following medications: *(Please check if *yes)*

- ☐ Alcohol
- ☐ Amoxicillin
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Darvon
- ☐ Erythromycin
- ☐ Iodine
- ☐ Latex Rubber
- ☐ Metals
- ☐ Nitrous Oxide
- ☐ Penicillin
- ☐ Percodan
- ☐ Sulfa Drugs
- ☐ Tetracycline
- ☐ Tylox
- ☐ Valium
- ☐ Vicodin
- ☐ Local Anesthetic (Novocaine)
- ☐ Other _____

Are you aware of being allergic to any other medication or substance? Yes ☐ No ☐

If yes, list them _____

Have you ever had any of the following: *(Please check if *yes)*

- ☐ Angina
- ☐ Rheumatic Fever
- ☐ Heart Surgery
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ Mitral Valve Prolapse
- ☐ Cardiac Pace Maker
- ☐ High Blood Pressure
- ☐ Heart Valve Replacement
- ☐ Stroke
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Bleeding Problems
- ☐ Anemia
- ☐ Leukemia
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Cancer
- ☐ Tumor or Growth
- ☐ Glaucoma
- ☐ Stomach Troubles
- ☐ Ulcers
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Tuberculosis
- ☐ Epilepsy
- ☐ Seizures
- ☐ Fainting
- ☐ Depression
- ☐ Anxiety
- ☐ Asthma
- ☐ Diabetes
- ☐ Respiratory Problems
- ☐ Hay Fever
- ☐ Emphysema
- ☐ Arthritis
- ☐ Hepatitis
- ☐ HIV-AIDS
- ☐ Sexually Transmitted Disease
- ☐ Artificial Joints
- ☐ Dental Implants
- ☐ Drug Addiction
- ☐ Alcoholism

Have you or are you now taking any Bisphosphonate Medications? Yes ☐ No ☐

Do you wear contact lenses? Yes ☐ No ☐

Has anyone in your family had diabetes? Yes ☐ No ☐

Do you smoke or use tobacco products? Yes ☐ No ☐

Have you ever been pre-medicated for dental treatment? Yes ☐ No ☐

If yes, type of medication _____

FOR WOMAN ONLY: *(Please check if *yes)*

Are you pregnant or think you may be? ☐ Are you nursing? ☐ Are you taking any oral contraceptives? ☐

Patient Signature (Parent of Guardian): _____ **Date** _____

Written Financial Policy • • •

Thank you for choosing **James K. Richards, DDS, PC**. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

1. Cash, Check, Visa, Mastercard, American Express or Discover Card

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash, check or credit card prior to completion of care for treatment plans of $300.00 or more.

2. Convenient Monthly Payment Plans from CareCredit *

- Allows you to pay over time
- No annual fees or pre-payment penalties

* Above terms subject to credit approval

Payment Terms

James K. Richards, DDS, PC requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and provide you with the documentation you need to receive reimbursement for your treatment.

A fee of $25 may be charged to patients who miss or cancel appointments without a 24 hour notice.

James K. Richards, DDS, PC charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

HIPAA Consent Form

Dr. James K Richards, DDS
1647 E. 18th
Loveland, CO 80538
P: 970.669.6111 F: 970.667.0971

Patient Name

Patient Phone

HIPAA – Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the notice Privacy Practice is to explain how James K Richards, DDS office may use or disclose your healthcare information. The notice also explains the rights that you are guaranteed under HIPAA regulations. Though James K Richards office has always taken great care to protect the integrity and confidentiality of your healthcare information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgment that you have received the notice. Signing below indicates that you have received the Notice of Privacy Practices.

I hereby acknowledge that I have received a copy of James K Richards, DDS Notice of Privacy Practices.

Patient or Guardian Signature

Permission to Share Medical Information

My medical information may be obtained and exchanged verbally to: _____
Name and Relationship

_____
Initials of Patient or Guardian

Communication Permission

Do we have your permission to leave appointment billing and dental information on your answering machine, voicemail or email at the following numbers/addresses?

Please check YES or NO for each contact method:

Home Phone	Yes ☐	No ☐
Work Phone	Yes ☐	No ☐
Mobile Phone	Yes ☐	No ☐
Text Messaging	Yes ☐	No ☐
Email	Yes ☐	No ☐
Mail	Yes ☐	No ☐

Patient or Guardian Signature

Date


SUBMIT FORM