

Welcome

I would like to take this opportunity to thank you for your patronage. I am pleased that you have chosen my office for your dental hygiene care. I strive to promote personalized dental hygiene services with a gentle touch and to provide you with the highest quality, most informative care available today at reasonable rates. Please understand that any diagnosis or assessment is for the purpose of determining necessary dental hygiene services only.

I consider all appointments as reservations in my schedule. If at any time you cannot keep an appointment, or need to reschedule this appointment, I ask that you give me more than 24 hour notice, in order that I may have plenty of notice to make this time available for another patient who may be waiting for an immediate opening.

Payment is expected on the day of service. Payment options include credit cards and approved payment plans.

Insurance claims for my patients are processed through my office at no charge. Insurance processing includes all insurance claim data input, postage, phone calls, and follow-up to be assured that my patients are reimbursed with their appropriate benefits. If requested, insurance estimates will also be provided, however, please keep in mind that these are only ESTIMATES and I cannot be responsible for any discrepancies. The insurance coverage is a contract between your employer, yourself and the insurance carrier. Your account is your responsibility regardless of insurance coverage.

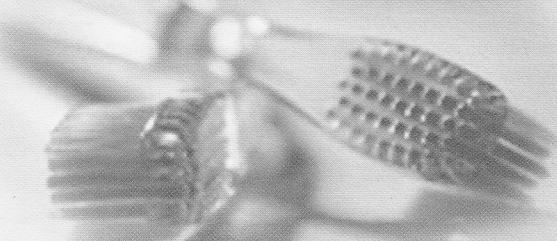
If at any time you have questions or concerns about your account or treatment, please do not hesitate to contact my office.

I ask that you understand clearly that in order to maintain your optimal dental health, that I do advise you of the **recommendations of the American Dental Association that it is important to see your dentist twice a year for dental examinations and the diagnosis of necessary restorative treatment**. I give authorization to Ellen Zanichelli, RDH, BS. or assignee to provide necessary dental radiographs and periodontal information to my dentist and/or my medical health care provider.

Name of Dentist: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____



Welcome

CONFIDENTIAL

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____

First Name _____ Middle Initial _____

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____ Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Date _____ Relationship to Patient _____

DENTAL HISTORY

Reason for today's visit _____

Burning sensation on tongue Yes No Mouth breathing Yes No

Former Dentist _____

Chew on one side of mouth Yes No Mouth pain, brushing Yes No

City/State _____

Cigarette, pipe, or cigar smoking Yes No Orthodontic treatment Yes No

Date of last dental visit _____

Clicking or popping jaw Yes No Pain around ear Yes No

Date of last dental X-rays _____

Dry mouth Yes No Periodontal treatment Yes No

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

Fingernail biting Yes No Sensitivity to cold Yes No

Bad breath Yes No Food collection between the teeth Yes No Sensitivity to heat Yes No

Bleeding gums Yes No Foreign objects Yes No Sensitivity to sweets Yes No

Blisters on lips or mouth Yes No Grinding teeth Yes No Sensitivity when biting Yes No

Gums swollen or tender Yes No Sores or growths in your mouth Yes No

Jaw pain or tiredness Yes No How often do you floss? _____

Lip or cheek biting Yes No

Loose teeth or broken fillings Yes No How often do you brush? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

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

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |

ALLERGIES

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

UPDATE (To be filled in at future appointment)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Periodontal Risk Assessment Questionnaire

Name _____

Date _____

Tobacco Use

Tobacco use is the most significant risk factor for gum disease.



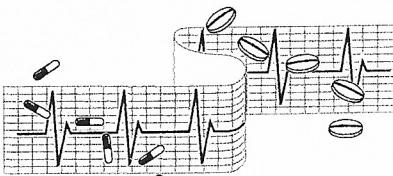
Blood Sugar



Diabetes

Gum disease is a common complication of diabetes.

Untreated gum disease makes it harder for patients with diabetes to control their blood sugar.



Heart Attack/Stroke

Untreated gum disease may increase your risk for heart attack or stroke.

Medications

A side effect of some medications can cause changes in your gums.



Family History/Genetics

The tendency for gum disease to develop can be inherited.



Do you now or have you ever used the following:

	Amounts per day	Used for how many years	If you quit, list what year
<input type="checkbox"/> Cigarette	_____	_____	_____
<input type="checkbox"/> Cigar	_____	_____	_____
<input type="checkbox"/> Pipe	_____	_____	_____
<input type="checkbox"/> Chewing	_____	_____	_____

IF YOU ARE A PATIENT WHO HAS DIABETES:

Is your diabetes under control? Yes No

Are you prone to diabetic complications? Yes No

How do you monitor your blood sugar? _____

Who is your physician for diabetes? _____

IF YOU ARE NOT A PATIENT WHO HAS DIABETES:

Any family history of diabetes? Yes No

Have you had any of these warning signs of diabetes?

- | | |
|---|--|
| <input type="checkbox"/> frequent urination | <input type="checkbox"/> excessive thirst |
| <input type="checkbox"/> excessive hunger | <input type="checkbox"/> weakness and fatigue |
| <input type="checkbox"/> slow healing of cuts | <input type="checkbox"/> unexplained weight loss |

Do you have any risk factors for heart disease or stroke?

- | | | |
|--|--|----------------------------------|
| <input type="checkbox"/> Family history of heart disease | <input type="checkbox"/> Tobacco use | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> High blood pressure | |

If you have any of these other risk factors it is especially important for you to always keep your gums as healthy as possible.

Are you taking or have you ever taken any of the following medication:

- Antiseizure medications. (such as Dilantin®, Tegretol®, Phenobarbital, etc.)
 Yes No

If you answered yes, are you still taking the anti-seizure medication?

- Yes No

Other Medication: _____

- Calcium Channel Blocker blood pressure medication. (such as Procardia®, Cardizem®, Norvasc®, Verapamil®, etc.)

Other: _____

- Immunosuppressant therapy (such as Prednisone, Azathioprine, Cyclosporins, Corticosteroids (Asthma-Inhalers), etc.)

Other: _____

Is there an immediate family member(s) who currently has or had gum problems in the past? (e.g. your mother, father, or siblings):

- Yes No



Heart Murmur, Artificial joint prostheses

If you have even the slightest amount of gum inflammation, bacteria from the mouth can enter the bloodstream and may cause a serious infection of the heart or joints.



Females

Females can be at increased risk for gum disease at different points in their lives.

Women

Women with osteoporosis have a greater risk for periodontal bone loss.



Stress

High levels of stress can reduce your body's immune defense.

Nutrition

Your diet has the potential to affect your periodontal health.



Do you have a heart murmur or artificial joint?

Yes No

If so, does your physician recommend antibiotics prior to dental visits?

Yes No

Name of physician? _____

If you answered yes, it is especially important to always keep your gums as healthy and inflammation-free as possible to reduce the chance of bacterial infection originating from the mouth.

The following can adversely affect your gums. Please check all that apply:

- Pregnant Nursing Menopause
 Taking birth control pills
 Infrequent care during previous pregnancies

Females:

Do you take any of the following:

- Estrogen Replacement Therapy/Hormone Replacement Therapy
(such as Prempro®, Premarin®, Premphase®, Fosamax®, Actonel®, Evista®, Forteo®, etc.)

Other: _____

Are you under a lot of stress?

Yes No

Do you find it difficult to maintain a well-balanced diet?

Yes No

All patients please complete the following:

Have you noticed any of the following signs of gum disease?

- | | |
|--|--|
| <input type="checkbox"/> Bleeding gums during toothbrushing | <input type="checkbox"/> Pus between the teeth and gums |
| <input type="checkbox"/> Red, swollen or tender gums | <input type="checkbox"/> Loose or separating teeth |
| <input type="checkbox"/> Gums that have pulled away from the teeth | <input type="checkbox"/> Change in the way your teeth fit together |
| <input type="checkbox"/> Persistent bad breath | <input type="checkbox"/> Food catching between teeth |

Is it important to keep your teeth for as long as possible?

Yes Not really

If you have missing teeth, why have you not had them replaced? _____

Do you like the appearance of your smile?

Yes No

Do you like the color of your teeth?

Yes No

Do your teeth keep you from eating any specific food?

Yes No

**Zanichelli Dental Hygiene, PC
Ellen Zanichelli, RDH,BS
4611 Plettner Lane, Suite 120
Evergreen, CO 80439
303-842-3609**

Acknowledgment of Privacy Practices

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

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.**
- Obtain payment from third-party payers for my health care services.**
- Conduct normal health care operations such as quality assessment and improved activities.**

I have been given the right to review (upon request) and receive a copy of such NOTICE OF PRIVACY PRACTICES. I understand that my dental hygiene provider has the right to change the NOTICE OF PRIVACY PRACTICES and that I may contact this office at the address above to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out dental hygiene treatment, payment or health care operations and I understand that 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: _____

Patient Signature: _____

Relationship to patient: _____

DEPENDENT FAMILY MEMBERS ALSO COVERED BY THIS ACKNOWLEDGMENT.

Financial Policy

My mission is to deliver the finest, most cost effective dental hygiene health care treatment available today. The following is a statement of my Financial Policy which I ask you to read and sign prior to any treatment.

Payment of today's visit and your future visits is due at the time of treatment. I am sensitive to the fact that some patients may not be able to pay cash for their treatment. Therefore, I do offer several options for your convenience.

1. Cash, check, Mastercard or Visa.
2. I offer an extended payment plan with prior credit approval. Please feel free to discuss these with me if needed.

Regarding dental insurance:

I accept assignment of insurance benefits. However, I do require any "non-covered" insurance expenses to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 60 days, the balance will become your responsibility and due at this time. Please be aware that some, and perhaps all, of the services I provide may be non-covered services and not considered reasonable and necessary under your particular policy.

A service charge of 1.5% per month (18% per annum) on any unpaid balance will be charged on all accounts with a balance exceeding 60 days unless previous written financial arrangements are agreed upon.

My practice is committed to provide the best treatment for my patients and I charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed appointments:

Please know that I respect your valuable time by doing my best to make sure all of your appointments begin promptly. In order to do that, I do not over book my days. I ask that you respect my time as I do yours and take responsibility for the appointments you make. If for any reason you are unable to keep your appointment, please telephone me at least 24 hours in advance to cancel. Unless cancelled 24 hours in advance, my policy is to charge for missed appointments at the rate of a normal office visit. Please help me serve you better by keeping scheduled appointments.

Thank you for understanding my Financial Policy. Please let me know if you have any questions or concerns. I have read the Financial Policy:

Patient Signature: _____ Date: _____

**Zanichelli Dental Hygiene, PC
Ellen Zanichelli, RDH, BS
4611 Plettner Lane, Suite 120
Evergreen, CO 80439
303-674-1373**

Dental Insurance

I understand that I will be charged for all dental hygiene treatment and that any part not covered by dental insurance is my responsibility. I understand that my dental insurance is a contract between the insurance carrier and me and not between the insurance carrier and the dental hygienist; therefore, I am still responsible for all dental hygiene fees. Payments received by Zanichelli Dental Hygiene, PC from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred.

I also understand that the dental hygiene office submits my insurance as a courtesy to me, but I am responsible for knowing the benefits and limitations of my policy.

Patient/Guardian Signature

Date