ARVADA IMPLANTS
& COSMETIC DENTISTRY

5169 W 64th Ave
Arvada, CO 80003
(720) 784-7773
info@arvadaimplantcenter.com

REGISTRATION FORM

Patient Name _____

Mailing Address _____

City _____ Zip Code _____

Male _____ Female _____ Single _____ Married _____ Other _____

Date of Birth _____ Social Security # _____

Phone # Home _____ Work # _____

Cell # _____ E-mail _____

Employer _____

Employer's address _____

Who may we thank for referral? _____

Emergency Contact _____ Phone # _____

IF PT UNDER AGE OF 18:

Mother Name: _____

Father Name: _____

INSURANCE INFORMATION

Name of Policy Holder _____

Policy Holders Birth Date _____ Social Security # _____

Policy Holders ID # _____

Insured's Employer Name _____

Insurance Plan Name _____

Insurance Group Name _____ Group # _____

Insurance Address _____

Insurance Co Phone Number _____

SECONDARY Insurance Plan _____ Group # _____

Policy Holder's Name _____ DOB _____

Social Security Number of ID # of Secondary Policy Holder _____

Address of Secondary Insurance _____

Please take a moment to enter or updated your information

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Please indicate if you have experienced any of the following:

YES	NO		YES	NO	
☐	☐	Artificial Joints (where?) _____	☐	☐	Allergies
☐	☐	Anemia	☐	☐	Arthritis
☐	☐	Alzheimer's	☐	☐	Asthma
☐	☐	Back Problems	☐	☐	Blood Disease
☐	☐	Cancer, where _____	☐	☐	Cholesterol
☐	☐	Diabetes	☐	☐	Dizziness
☐	☐	Excessive Bleeding	☐	☐	Epilepsy
☐	☐	Fibromyalgia	☐	☐	Fainting
☐	☐	Head Injuries	☐	☐	Glaucoma
☐	☐	Heart Murmur	☐	☐	Heart Disease
☐	☐	High Blood Pressure	☐	☐	Hepatitis A___ B___ C___
☐	☐	Jaundice	☐	☐	HIV
☐	☐	Liver Disease	☐	☐	Kidney Disease
☐	☐	Nervous Disorder	☐	☐	Mental Disorders
☐	☐	Parkinson's	☐	☐	Pacemaker
☐	☐	Radiation Treatment	☐	☐	Pregnancy
☐	☐	Chemo Treatment	☐	☐	Rheumatism
☐	☐	Rheumatic Fever	☐	☐	STD
☐	☐	Sinus Problems	☐	☐	Stroke
☐	☐	Stomach Problems	☐	☐	Tuberculosis
☐	☐	Tumors, where _____	☐	☐	Ulcers or Acid Reflux
☐	☐	Venereal Disease	☐	☐	OTHER _____

Any other Health Issues? _____

_____

Please list all medications that you are currently taking

_____

_____

_____

Are you required to have PRE-MEDICATION prior to dental treatment? ☐ Yes ☐ No
If yes, what type of Pre-Med? ☐ Amoxicillin ☐ Clindamycin ☐ Penicillin ☐ Other _____

Are you allergic to the following?

Aspirin	☐ Yes	☐ No	Codeine	☐ Yes	☐ No	Erythromycin	☐ Yes	☐ No
Latex	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No	Sulfa Drugs	☐ Yes	☐ No

Other_____

WOMEN ONLY Are you pregnant? ☐ Yes ☐ No
If yes, when is the due date? _____

By signing, the above medical information is true to my knowledge.

SIGNATURE _____ **DATE** _____

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MEDICAL AND DENTAL HISTORY

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well being.

Would you consider yourself to be in fairly good health? ☐ Yes ☐ No
Within the past year, have there been any changes in your general health? ☐ Yes ☐ No
What is the approximate date of your last medical exam? _____
Primary care Physicians Name, Address and Phone Number _____
_____

☐ Yes ☐ No Have you ever had any complications following dental treatment?
☐ Yes ☐ No Are you currently under the care of a physician due to a specific condition?
☐ Yes ☐ No Have you been hospitalized within the last 5 years due to a surgery or illness?
☐ Yes ☐ No Are you currently taking any prescriptions or non-prescription medications?
☐ Yes ☐ No Do you use tobacco? (Smoking or chewing?)
☐ Yes ☐ No Do you require the use of corrective lenses? (Contacts or glasses)?
☐ Yes ☐ No Do you have any other conditions, diseases, etc. not listed that we should be aware of?
If yes, please indicate _____

What is the reason for your dental visit today? _____
Name of prior dentist _____
When was your last visit to the dentist _____
How often do you brush? ☐ Once a day ☐ Twice a day ☐ Weekly ☐ Seldom
How often do you floss? _____
Do your teeth experience sensitivity to cold or hot temperatures? ☐ Yes ☐ No
Are any of your teeth currently causing you pain? ☐ Yes ☐ No
Do you grind your teeth (either consciously or during sleep?) ☐ Yes ☐ No
Are of your teeth loose? ☐ Yes ☐ No
Do you currently have any dental implants, dentures or partials? ☐ Yes ☐ No

We are happy to submit your dental claims to your insurance. Please note that you will be responsible for any and all charges not paid for insurance. We ask that you pay your portion at the start of treatment, unless other arrangements are made.

Signed _____ **Date** _____

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AGREEMENT

I understand that my employer provides me with dental insurance which helps offset my dental costs. Dr. Tariq Sawaqed works for himself, not the insurance companies/ Medicaid. He sets his own fees, the insurance companies do not. In some instances there is only a fee agreement with an insurance company. Dental insurance is a contract between you and your insurance company / Medicaid. We are not a party to this contract and cannot guarantee what your contract states.

I understand in advance that I am entirely responsible for the total charge incurred regardless on insurance coverage. As a courtesy, our office will file your insurance claim if you provide us with the proper information. I understand that Dr. Sawaqed accepts the insurance company's/ Medicaid verification of benefits in good faith that the claim will actually be covered as described by the insurance company / Medicaid. Although we estimate what your insurance company / Medicaid may pay, it is the insurance company / Medicaid that makes the final determination of your eligibility. The office will collect the estimated patient **out-of-pocket of your total charge** at the time of service. **Our office cannot guarantee your insurance / Medicaid will pay for the total amount of services.** To avoid disappointment, we encourage you to call your insurance and listen to their disclaimer regarding coverage. In the event that the insurance company **does not pay** the claim for the treatment charges, I am **responsible for all charges** for dental services that I or my dependents have incurred and authorized in our treatment. A bill will be sent for any portions unpaid by the insurance.

Upon default, I am responsible for 24% per annum interest, cost of collection, and attorney's fees even if no lawsuit is filed.

I understand that this office will help my insurance / Medicaid coverage to me but I, as the patient or guardian, am fully and solely responsible for understanding my insurance coverage: yearly maximum, deductible, frequencies, exclusions, etc.

I understand that the office will bill my primary insurance company / Medicaid. The bill my secondary insurance company. I secondary claim but will not wait for payment from them.

I understand that this office does not directly offer payment plans. The office currently offers payment through CareCredit , Lending Club and Simple Pay. I will need to ask for the information on how I can apply for the plans that are offered through this office.

I understand there is a **$75.00** charge if I do not cancel my appointment more than **24** hours prior to its scheduled time or do not show up for the appointment. In addition, there is a $50.00 charge for returned checks. Accounts are referred to collections at 90 days.

I understand that I will need to request in writing and pay $25.00 pre-paid copying fee to have copies of my records sent to another doctor. I understand this will include all relevant information including my payment history.

I understand that reminder calls for appointments are only done as a courtesy.

I have read and understand the above policies and my signature indicates my agreement to abide by this agreement of the financial policy.

_____ _____

Patient's signature over printed name **Date**

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1966 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

* Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
* Obtaining payment from third party payers (e.g. insurance company)
* The day-to-day healthcare operations of the practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are the bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Printed Patient Name _____

Signature _____ **Date** _____

Relationship to the Patient _____