MAUCK & RICCI, DDS.

PATIENT INFORMATION

Date _____

First Name _____ Last Name _____ Middle Initial _____

Preferred Name _____ Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Domestic Partner

Birth Date _____ Social Security # _____

Employer _____ Occupation _____

Who may we thank for referring you to our office? _____

E-mail Address _____

Drivers License # _____

Emergency Contact _____ Phone _____

Spouse _____ Spouse Employer _____ Spouse Employer Ph. # _____

RESPONSIBLE PARTY INFORMATION

Who is responsible for the account? _____

_____

Relationship to Patient _____ Birth Date _____ Drivers License # _____

Social Security # _____ E-mail Address _____

Address _____ Phone (cell/hm) _____ Office: _____

City, State, Zip _____

Employer _____ Occupation _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Insured's Birth Date _____ Insured's Social Security # _____

Employer _____ Date Employed _____ Occupation _____

Insurance Company _____

Claims/Insurance Company Address _____

City, State, Zip _____

Group # _____ Subscriber ID# _____

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Insured's Birth Date _____ Insured's Social Security # _____

Employer _____ Date Employed _____ Occupation _____

Insurance Company _____

Claims/Insurance Company Address _____

City, State, Zip _____

Group # _____ Subscriber ID# _____

CONSENT

I understand that responsibility for payment of dental services in this office for myself and my dependents is mine; due and payable at the time services are rednered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). Insurance claims are filed as a courtesty, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I also assign all benefits to Name of Provider. I authorize the submission of claims without obtaining my signature on each and every claim submitted. I give an authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my dentist. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this provider and its employees, agents and assignees to contact me via e-mail, text messaging and to my cellular devices.

Signature _____ Date _____

Dentist Signature _____ Date _____

MEDICAL HISTORY

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

- ☐ A-FIB
- ☐ AIDS/HIV Pos.
- ☐ Alcoholism
- ☐ Allergies-Seasonal
- ☐ Alzheimer/Dementia
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis/Rheumatoid Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints (hip, knee, etc.)
- ☐ Asthma
- ☐ Bishphosphonate Therapy
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart Lesions
- ☐ Diabetes
- ☐ Cosmetic Surgery
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Emphysema/COPD
- ☐ Epilepsy or Seizures
- ☐ Fever Blisters
- ☐ Gerd
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Disease or Attack
- ☐ Heart Murmur
- ☐ Heart Peacemaker/Stent
- ☐ Heart Surgery
- ☐ Hemophilia (bleeding problems)
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Trouble
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ MS
- ☐ Nervousness
- ☐ Osteoporosis
- ☐ Pain in Jaw Joint
- ☐ Pregnant (presently)
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Sinus Trouble
- ☐ Sleep Apnea/C-pap
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tobacco (any form)
- ☐ Tuberculosis (TB)
- ☐ Ulcers

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐

Explain: _____

_____

_____

LIST ALL MEDICATIONS (you're currently taking)

_____

_____

_____

_____

_____

_____

_____

_____

_____

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

- ☐ Aspirin
- ☐ Codeine
- ☐ Epinephrine
- ☐ Erythromycin
- ☐ Latex (balloon, gloves, etc.)
- ☐ Local Anesthetic
- ☐ Nitrous Ocide
- ☐ Penicillin
- ☐ Sulfa

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, DATE:		
Last FULL MOUTH X-RAYS, DATE: ○ 20 Small Films ○ Panoramic		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health GOOD?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Are you Interested in Permanent Tooth Replacement?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth? (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Name of Previous Dentist:		
City: State:		
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment		
FEAR of pain # LACK of concern #		
COST of treatment # MISSING work time #		

Are you aware of being allergic to any other medications or substances?

If Yes, please list: _____

_____

_____

Is there any other Medical or Dental information that you feel I should know about? _____

_____

_____

_____

_____

Family Physician _____ Phone No. _____

Signature _____ Date _____

MAUCK & RICCI, DDS.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect _9_/_1_/_2018_, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Dr. Andrew Ricci DDS

Signature: _____

Printed Name: _____

MAUCK & RICCI, DDS.

3131 S Vaughn Way, Ste 422
Aurora, CO. 80014
303-745-1400

Authorization for the Disclosure of PHI to Family/Spouse

As required by the Health Insurance Portability and Accountability Act of 1996 Mauck and Ricci, PLLC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

Authorization Section

_____

I._____hereby authorize the disclosure of any of my health information to the following people:
Print patient name

1._____Relationship_____

2._____Relationship_____

3._____Relationship_____

4._____Relationship_____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that I may revoke this authorization at any time by signing the revocation section of my copy of the form and returning it to Mauck and Ricci, PLLC. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment at Mauck and Ricci, PLLC will not depend in any way on whether I sign this authorization or not. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand that this authorization will automatically expire:

On___/___/___ or when I revoke this authorization—whichever comes first.

Signed:_____ Date:_____

Print name:_____Telephone:_____

MAUCK & RICCI, DDS.

PRESCRIPTION DRUG MONITORING NOTIFICATION

By signing this form, you confirm you that you have been notified that if you receive a prescription for a controlled substance (narcotic drug) from our office and fill that prescription at a pharmacy in Colorado. Certain identifying prescription information, including the name of the patient, will be entered into a secure database maintained by Colorado's prescription drug monitoring program. State law requires pharmacies to record information about controlled substance prescriptions filled to the prescription drug monitoring database.

The database is used to help prevent inappropriate used of controlled substances- like fraud and diversion. The prescription drug monitoring program database contains only records related to controlled substances (narcotic drugs like painkillers, muscle relaxants and steroids). It does not contain records about other prescription drugs like antibiotics, antidepressants or any other category of prescription medication.

Only authorized individuals, like healthcare personnel that prescribe controlled substances and law enforcement under very limited circumstance, can access the database and only for tightly defined used. As long as you are using controlled drugs appropriately, there shouldn't be reason for concern. If you do not want your information in the database, please ask your dentist to prescribe non-narcotic drug for you.

More information about Colorado's prescription drug monitoring program, including copies of individual prescription drugs records stored in the database, can be obtained from the Colorado state Department of Regulatory Agencies by calling 303-894-5957 or by visiting

http://www.dora.state.co.us/pharmacy/pdmp/consumers.htm

I have read and understand this notification.

_____ _____

Date Signature of patient/guardian

If this notification is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

MAUCK & RICCI, DDS.

Authorization to Release Dental Records

Please release the dental records for the following patient:

Patient Name: _____

Date of Birth: _____

Please include copies of current x-rays and any other information related to this patient. Including any implant information if applicable.

Purpose for which information is needed:

_____Transfer of records _____ Second Opinion
_____Other

Please forward the above requested information to:

Matt Mauck, DDS
Andrew Ricci, DDS
3131 S. Vaughn Way, Ste 422
Aurora, CO. 80014
303-745-1400

Or email to: info@betteryoursmile.com (We prefer Dexis or Jpeg)

Patient Name (please print): _____

Patient Signature: _____