Welcome to Copper Canyon Family Dentistry

Patient Information

First Name:_____ Last Name:_____ Middle Initial:_____

Name Patient Goes By: _____ Birthdate:_____ Age:____ Gender:_____

Mailing Address: _____ Name of Employer:_____

Social Security # *(required if patient is the policyholder for the dental ins.)*:_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Email Address:_____ Preferred Pharmacy:_____

Previous Dentist:_____ Approx. Date of Most Recent Dental Visit:_____

Referred to Our Office By:_____ Emergency Contact Name & Number:_____

☐ = I **do** have a dental insurance card ☐ = I do **not** have a dental insurance card

Name of Dental Insurance *(if patient is the policyholder)*:

Primary Dental Insurance Information *(Parent Information if Patient is Under 18)*

☐ = Same as above *(skip to the next page)* ☐ = No insurance *(skip to the next page)*

Policyholder First Name:_____ Last Name:_____

Birthdate:_____ Gender:____ Relationship to Patient:_____

Social Security # *(required if we are filing dental insurance)*:_____

Mailing Address: _____

Cell Phone:_____ Home Phone:_____ Email:_____

Name of Employer:_____

Name of Dental Insurance Company:_____

Name of Medical Insurance Company:_____

Secondary Dental Insurance Information *(if applicable)*

Policyholder First Name:_____ Last Name:_____

Birthdate:_____ Gender:____ Relationship to Patient:_____

Social Security # *(required if we are filing dental insurance)*:_____

Mailing Address: _____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Email Address:_____

Name of Employer:_____

Name of Dental Insurance Company:_____

☐ = I **do** have a secondary dental insurance card ☐ = I do **not** have a dental insurance card

Medical History

	Y	N	If yes, please elaborate:
Are you currently under a physician's care?			
Have you been hospitalized/had a surgery?			
Have you ever had a head or neck injury?			
Are you taking any medications, pills, drugs?			
Have you ever taken Phen-Fen or Redux?			
Have you ever taken Boniva, Fosamax, Actonel, or meds with bisphosphonates?			
Are you on a special diet?			
Do you use tobacco?			
Do you use controlled substances?			

Are you allergic to any of the following:
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Other:

Women, are you: ☐ Pregnant/Trying to Get Pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

Have you ever had the following?	Y	N		Y	N		Y	N		Y	N
AIDS/HIV Positive			Cortisone Medicine			Hemophilia			Radiation Treatment		
Alzheimer's			Diabetes			Hepatitis A			Recent Weight Loss		
Anaphylaxis			Drug Addiction			Hepatitis B or C			Renal Dialysis		
Anemia			Easily Winded			Herpes			Rheumatic Fever		
Angina			Emphysema			High Blood Pressure			Rheumatism		
Arthritis/Gout			Epilepsy or Seizures			High Cholesterol			Scarlet Fever		
Artificial Heart Valve			Excessive Bleeding			Hives or Rash			Shingles		
Artificial Joint			Excessive Thirst			Hypoglycemia			Sickle Cell Disease		
Asthma			Fainting/Dizziness			Irregular Heartbeat			Sinus Trouble		
Blood Disease			Frequent Cough			Kidney Problems			Spina Bifida		
Blood Transfusion			Frequent Diarrhea			Leukemia			Stomach/Intestinal Disease		
Breathing Problems			Frequent Headaches			Liver Disease			Stroke		
Bruise Easily			Genital Herpes			Low Blood Pressure			Swelling of Limbs		
Cancer			Glaucoma			Lung Disease			Thyroid Disease		
Chemotherapy			Hay Fever			Mitral Valve Prolapse			Tonsillitis		
Chest Pains			Heart Attack/Failure			Osteoporosis			Tuberculosis		
Cold Sores/Fever Blisters			Heart Murmur			Pain in Jaw Joints			Tumors or Growths		
Congenital Heart Disorder			Heart Pacemaker			Parathyroid Disease			Ulcers		
Convulsions			Heart Disease			Psychiatric Care			Venereal Disease		
									Yellow Jaundice		

Have you had any serious illness not listed above? ☐ No ☐ Yes (If yes, please elaborate):

Comments:

To the best of my knowledge, this form has been accurately completed. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any medical changes.

Printed Name: Signature: Date:

COPPER CANYON FAMILY DENTISTRY

Copper Canyon Family Dentistry
6830 Montgomery Blvd NE, Ste A, Albuquerque, NM 87109, USA
(505) 830 9081
www.coppercanyonfamilydentistry.com/

FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide your family with the highest quality dental care in a gentle and enjoyable atmosphere. It is our policy to make financial arrangements with you before any treatment begins. Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

MISSED APPOINTMENTS

We do our best to reach our patients. The office communicates via call, text, email, and mail. If you have an update to your contact information, it is your responsibility to provide this to the office.

1. In order to provide the best possible service and availability to all of our patients, please be on time for each of your appointments. Showing up late will cause our staff to run behind for the next scheduled patient.

2. Should you need to cancel or reschedule your appointment, we require 24 hours notice to avoid a **$50.00 broken appointment fee**. Our office can be reached via phone, email, and text. We have reserved a block of time specifically for you. When you do not provide sufficient notice, you are taking an appointment away from another patient who can be seen at the time you have reserved.

3. Multiple late and broken appointments may result in dismissal from our practice.

PAYMENT

Payment is due at the time of service. This applies to patients who have not provided sufficient insurance information for us to file, who have an estimated copay or estimated coinsurance, who receive payment directly from their insurance or reimbursement from an FSA/HSA account, or who have had a delinquent account with us in the past. If treatment is being performed, we will collect an estimated coinsurance at the time of service. It is rare for any insurance company to pay 100% for treatment such as crowns, implants, and other services.

INSURANCE

Accurate insurance information must be provided by the patient. As a courtesy, our office will file your insurance a maximum of two times per appointment. If the claim has not been paid within 30 days, you will be responsible for the full balance. After that, we will be happy to provide you with a claim form so that you can follow up on your insurance claims personally.

The social security number of the policyholder or an alternate ID number is required for us to file insurance. We also need a mailing address for your dental claims. Payment is due in full if this information is not available at the time of service or if your insurance company does not show that your coverage is currently in effect.

If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and/or any applicable estimated coinsurance at the time of service. You are responsible for paying all charges not covered by

your insurance company, including all fees considered above your insurance companys usual and customary fee schedule. Your insurance benefits are a contract between you and your employer. **The amount of coverage you will receive will depend on the quality of the insurance plan purchased, not the fees of the doctor.** A statement will be sent if the insurance company payment is insufficient to cover the balance.

Your insurance eligibility may be verified as a courtesy. At no time will this guarantee coverage. It is the responsibility of the insured to be aware of their insurance coverage and benefits available. You, as the patient, are responsible for finding out from your insurance company whether certain procedures must be pre-authorized, or what costs are not covered by your insurance company. Any charges not covered by insurance are the financial responsibility of the patient and the insured.

The office cannot carry balances longer than 90 days, including if the insurance is still pending.

When your insurance has paid or 30 days from the appointment date has been reached, whichever comes first, we will notify you if there is a balance. After two notices, your account is subject to a late payment fee. After 60 days, we will inform you of the delinquency by letter. If no action is taken to resolve the balance, the office will be required to employ a collection service. The responsible party agrees to pay all related collection fees. We never reappoint patients after their account has been turned over to a collection agency.

There is a $30 service charge for all returned checks. Payment of the full balance is due within 5 business days to avoid collection proceedings.

✓ I confirm and agree

Patient's signature: Date:

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PRIVACY POLICY CONSENT - HIPAA

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 6830 Montgomery Blvd NE, Ste A, Albuquerque, NM 87109, USA:

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as Psychotherapy Notes. All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the clients medical records to maintain a higher standard of protection. Psychotherapy Notes are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individuals medical records. Excluded from the Psychotherapy Notes definition are the following: (a) medication prescription and

monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individuals dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

✓ I confirm and agree

Patient's signature: Date:

Copper Canyon Family Dentistry
6830 Montgomery Blvd NE, Ste A
Albuquerque, NM 87109
P: 505-830-9081 F: 505-830-9086

Acknowledgment of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgment

I have received a copy of this office's Notice of Privacy Practices

Print name: _____

Signature: _____

Date: _____

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement

- ☐ Other (please specify): _____
  _____
  _____

Copper Canyon Family Dentistry
Seth J. Stockton, DMD and Erin E. Stockton, DMD
6208 Montgomery Blvd. NE Ste C, D
Albuquerque, NM 87109
(505) 830-9081

Dental Records Release Form

Patient Name: _____

Patient's Date of Birth: _____ Patient's Chart Number: _____

Patient's Date of Death, if applicable: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed:

- ☐ Designated Records Set
- ☐ Other:_____

Purpose(s) of this use or disclosure:

- ☐ Transferring dental providers
- ☐ Other:_____

[If the patient or the patient's personal representative is requesting the use or disclosure, you may write "at the request of the individual" for the purpose.]

Name of entity you are authorizing to **release** your records:

- ☐ Copper Canyon Family Dentistry
- ☐ Other:_____

Name of entity you are authorizing to **receive** your records:

- ☐ Copper Canyon Family Dentistry (coppercanyonfamily@gmail.com)
- ☐ Other:_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at 6208 Montgomery Blvd NE #C, D; Albuquerque, NM 87109. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires one year from the signature date.

Signature of Patient/Patient's Personal Representative:

_____ Date: _____

If Personal Representative: Print Name: _____

Relationship to Patient: _____

For Office Use Only

Copy of signed authorization provided to the individual:

Date: _____ Initials: _____