18695 Stage Run
Parker, CO 80134
303-841-8600

PATIENT INFORMATION

Date: _____

Cell Phone Number: (_____)-_____

Alternative Number: (_____)-_____ Type? □ Work □ Cell □ Home

Name _____ Birthdate_____
Last First Middle Initial

Sex □ M □ F □ Married □ Widowed □ Single □ Minor □ Separated □ Divorced

Social Security Number: _____ E-mail: _____

Address: _____

City_____ State_____ Zip_____

Patient Employer/School: _____ Occupation: _____

Employer/School Address_____ Employer/School Phone (___)-_____

Whom may we thank for referring you? _____

Or, how did you hear about us? _____

In case of emergency who should be notified? _____ Phone (_____)-_____

_____ Phone (_____)-_____

LOEPPKEDENTAL
COSMETIC AND FAMILY DENTISTRY

PREVIOUS DENTAL INFORMATION

Former Dentist Name: _____ Last dental visit: _____

Former Dental Practice Contact Information: _____

CURRENT ACCOUNT INFORMATION

Person Responsible for Account _____
Last First Middle Initial

Relation to Patient _____ Birthdate_____ Soc. Sec. #_____

Responsible Party Employed by_____ Phone (_____) -_____

Business Address_____ Business Phone (_____) -_____

DENTAL INSURANCE INFORMATION

Subscriber Name: _____ Birthdate: _____ Soc. Sec. # _____

Employer: _____ Insurance Company Name: _____

Member Id#_____ Group # _____ Group Name: _____

Family Plan: □ Yes □ No Please List Dependents: _____

_____

ADDITIONAL DENTAL INSURANCE INFORMATION

Is patient covered by additional insurance? □Yes □No

Subscriber Name: _____ Birthdate: _____ Soc. Sec. # _____

Employer: _____ Insurance Company Name: _____

Member Id#_____ Group # _____ Group Name: _____

Family Plan: □ Yes □ No Please List Dependents: _____

LOEPPKEDENTAL
COSMETIC AND FAMILY DENTISTRY

MEDICAL HISTORY

It is important that we know about your medical history. Many factors have a direct bearing on our health. We will review the questionnaire and discuss this with you in detail. Information provided below is strictly confidential and will not be released to anyone without your written permission.

Physician's Name: _____Date of Last Physical Examination: _____

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

Do you now or have you ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa? □ Yes □ No If so, which drug? _____

Have you had any serious illnesses or operations? □ Yes □ No

If yes, please describe _____ Date: _____

Have you ever had a blood transfusion? □ Yes □ No If yes, give dates: _____

Are you Pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Do you have or have you had any of the following conditions **(Please mark Yes or No):**

Yes No	Yes No	Yes No	Yes No
□ □ Anemia	□ □ Cortisone Treatments	□ □ Hepatitis	□ □ Scarlet Fever
□ □ Arthritis, Rheumatism	□ □ Cough, Persistent	□ □ High Blood Pressure	□ □ Shortness of Breath
□ □ Artificial Heart Valves	□ □ Cough up Blood	□ □ HIV/AIDS	□ □ Skin Rash
□ □ Artificial Joints	□ □ Diabetes	□ □ Jaw Pain	□ □ Stroke: When? _____
□ □ Asthma	□ □ Epilepsy	□ □ Kidney Disease	□ □ Swelling of Feet or Ankles
□ □ Back Problems	□ □ Fainting	□ □ Liver Disease	□ □ Thyroid Problems
□ □ Blood Disease	□ □ Glaucoma	□ □ Mitral Valve Prolapse	□ □ Tobacco Habit
□ □ Cancer: _____	□ □ Headaches	□ □ Pacemaker	□ □ Tonsillitis
□ □ Chemical Dependency	□ □ Heart Murmur	□ □ Radiation Treatment	□ □ Tuberculosis
□ □ Chemotherapy	□ □ Heart Problems	□ □ Respiratory Disease	□ □ Ulcer
□ □ Circulatory Problems	□ □ Hemophilia	□ □ Rheumatic Fever	□ □ Venereal Disease

Medications:

Please list ALL medications you are taking:

_____

_____

_____

Allergies:

Please list any allergies: _____

_____

_____

_____

SIGNATURE: _____DATE: _____

LOEPPKEDENTAL
COSMETIC AND FAMILY DENTISTRY

TERMS AND CONDITIONS

INSURANCE CONTRACTS: Insurance plans represent a contract between yourself and the insurance company. These contracts are not between the doctor and the insurance company. We will do our best to assist you in obtaining your benefits, but we cannot be responsible if your carrier does not pay. Our office will bill your insurance carrier as a courtesy to you.

Payment will be expected at the time of service for all non-contracted fees and estimated co-pays.

Financial arrangements are available upon request and must be discussed prior to the recommended treatment. This practice depends upon reimbursement from its patients for the costs incurred for their care. Financial responsibility for each patient must be determined before treatment.

All emergency dental services or any dental services performed without prior financial arrangements and or dental insurance information must be paid for in cash, check, or credit card at the time services are rendered.

Insurance is not a guarantee of payment, our office will utilize every effort to bill insurance on your behalf, and provide your insurance carrier with any supporting documentation needed on your behalf. The patient is responsible for any estimated insurance and patient portion. ***Our office will allot a 45 day grace period to coordinate payment from your insurance carrier. If your insurance has not paid the FULL BALANCE within 45 days of the date of service you will be required to settle the balance in full.*** A finance charge of 18% APR (1.5% a month) will be added to the total balance on all accounts over 60 days past due.

When deemed necessary your account may be turned over to collection agency for non-payment or delinquency. The patient will be responsible for payment of any and all collection costs including court costs, attorney fees, and the balance owed. All accounts turned over to a collection agency forfeit any past special fees or discounts (i.e. cash discount).

Our office reserves the right to dismiss you from the practice. All currently scheduled appointments will be cancelled, and you will be allowed 30 days in which you will be seen on an emergency basis with our office.

MISSED APPOINTMENTS: Our office policy does require a minimum 2 business day notice for any changes in your scheduled appointments. We do reserve the right to charge a minimum $80.00 Broken Appointment Fee. These fees may vary per the scheduled time slot that has been reserved for your appointment. Prime appointment times (E.g. 7:00am, 5:00pm) may result in a higher fee.

The undersigned hereby agrees to pay any and all balances accrued on their account for dental services rendered after their insurance provider pays their determined amount, regardless if said charges are deemed over and above the predetermined rates.

I, the undersigned, grant permission to this office to telephone me at home or work to discuss matters related to this form. I have read and understand the above conditions of treatment and agree to their content.

PRINT NAME: _____

SIGNED: _____ DATE: _____

LOEPPKEDENTAL
COSMETIC AND FAMILY DENTISTRY

PRESCRIPTION DRUG MONITORING NOTIFICATION

By signing this form, you confirm 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 report information about controlled substance prescriptions filled to the prescription drug monitoring database.

This database is used to help prevent inappropriate uses 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 circumstances, can access the database and only for tightly defined uses. 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 drug 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

OR, if applicable

_____ Date: _____
Signature of Legal Guardian

LOEPPKEDENTAL
COSMETIC AND FAMILY DENTISTRY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

*_____ I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Brita and Matthew Loeppke, DDS have the right to change their *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

*_____ I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

***(Please initial)**

HIPAA AUTHORIZATION

(Permission from patient/patient's legal guardian to share personal medical information)

I, _____, hereby authorize Brita and Matthew Loeppke, DDS Prof LLC to release
NAME OF PATIENT

any and all medical information that may pertain to me to the following individual(s):

Name: _____ Phone #: (_____)-_____ Relationship to Pt: _____

Name: _____ Phone #: (_____)-_____ Relationship to Pt: _____

I authorize Brita and Matthew Loeppke, DDS PLLC to contact the individual(s) listed above to convey any pertinent information about me, in the event that I am unable to be reached by the facility.

I understand that I may revoke/cancel this authorization by notifying Brita and Matthew Loeppke, DDS PLLC in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is released.

_____ Date: _____
Signature of Patient

OR, if applicable

_____ Date: _____
Signature of Legal Guardian

HIPPA Notice of Privacy Practices

Brita and Matthew Loeppke, DDS PLLC | 18695 Stage Run, Parker, CO 80134 | (303) 841-8600

Effective as of March 1, 2010

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment | We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment | Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations | We may use or disclose, as allowed by law, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, and licensing. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. **You may revoke this authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights | The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information | *(fees may apply)* – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your health information | This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications | You have the right to request confidential communication from us by alternative means or at an alternative location. You may have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information | If we deny your request for amendment, you the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures | You have the right to receive an accounting of all disclosures except for disclosures: pursuant to authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Complaints | You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Offer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgement" form. Please note that by signing the Acknowledgement form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.