AMBIDA
FAMILY DENTISTRY, P.C.

DR. SANDRA C. AMBIDA

9695 S. Yosemite St. #225
Lone Tree, Co. 80124

P: 303-790-TEETH (8338)
F: 303-790-8339

www.ambidadental.com

WELCOME TO AMBIDA FAMILY DENTISTRY!

WE ARE HERE TO HELP YOU AND MAKE YOUR VISIT *COMFORTABLE AND EASY*.

PLEASE FILL OUT FORMS PRIOR TO COMING TO OUR OFFICE.

PLEASE REMEMBER TO BRING YOUR DENTAL INSURANCE CARD AND A FORM OF I.D.

IF YOU HAVE ANY QUESTIONS REGARDING THESE FORMS, PLEASE DO NOT HESITATE TO CALL US AT:
303-790-8338.

IF YOU WOULD PREFER TO FAX YOUR INFORMATION AHEAD OF TIME SO THAT WE CAN CALL TO VERIFY YOUR INSURANCE AND YOUR COVERED BENEFITS, PLEASE DO SO AT:
FAX: 303-790-8339

OUR ADDRESS IS:
LONE TREE MEDICAL BUILDING
9695 S. YOSEMITE ST. #225
LONE TREE, COLORADO 80124

COMING FROM THE I-25, WE ARE LOCATED 1 MILE WEST OF THE I-25 AT LINCOLN AVE. FROM LINCOLN, GO NORTH ONTO YOSEMITE ST. WE ARE IN THE LONE TREE MEDICAL BLDG ON THE LEFT SIDE. (THE PINK BLDG!)

COMING EASTBOUND FROM C-470, EXIT ONTO YOSEMITE ST. GOING SOUTH (RIGHT TURN). WE ARE LOCATED ABOUT 2 MILES SOUTH OF C-470. WE ARE ON THE RIGHT SIDE IN THE LONE TREE MEDICAL BLDG. (The pink building where the Urgent Care Center is located!)

AGAIN, THANK YOU FOR CHOOSING
AMBIDA FAMILY DENTISTRY!

AMBIDA
FAMILY DENTISTRY, P.C.

DATE:_____

LAST NAME:_____**FIRST:**_____**M.I.**_____

ADDRESS:_____

CITY:_____**STATE:**_____**ZIP:**_____

HOME PHONE:_____**WORK PHONE:**_____

CELL PHONE:_____**FAX:**_____

MAY WE HAVE YOUR PERMISSION TO CONTACT YOU AT YOUR WORK NUMBER? YES NO

DOB:_____**SEX: M F MARITAL STATUS: S M D W**

SOCIAL SECURITY NUMBER:_____ **OCCUPATION:**_____

PERSON *RESPONSIBLE* FOR ACCOUNT:_____

RELATIONSHIP TO PATIENT (if applicable):_____

***PREFERRED NAME*:**_____

EMAIL ADDRESS:_____

May we use your email as a way to contact you? Yes No

EMERGENCY CONTACT PERSON AND RELATIONSHIP_____

PHONE_____ **OTHER PHONE**_____

INSURANCE INFORMATION:

PRIMARY INS. COMPANY:_____

I.D. NUMBER:_____**GROUP NUMBER:**_____

INSURANCE ADDRESS:_____

EMPLOYER:_____

NAME OF EMPLOYEE ON INSURANCE:_____**DOB:**_____

SOCIAL SECURITY # OF PERSON WHO HAS THE INSURANCE POLICY:_____

RELATIONSHIP OF POLICY HOLDER TO PATIENT: _____

SECONDARY INS.COMPANY:_____ _____

I.D. NUMBER:_____**GROUP NUMBER:**_____

INSURANCE ADDRESS:_____

EMPLOYER:_____

NAME OF EMPLOYEE ON INSURANCE:_____**DOB:**_____

SOCIAL SECURITY # OF PERSON WHO HAS THE INSURANCE POLICY:_____

RELATIONSHIP OF POLICY HOLDER TO PATIENT: _____

DEPENDENTS UNDER INSURANCE:

_____
_____

_____
_____

_____
_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE:_____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of any changes. I also understand that Ambida Family Dentistry, P.C. submits claims as a* COURTESY, *and I will be responsible for payment if I do not have my correct insurance, and the like, available.

SIGNATURE:_____**DATE:**_____

SIGNATURE OF GUARDIAN:_____**DATE:**_____

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FAMILY DENTISTRY, P.C.

PRIVACY NOTICE - HIPPA

This notice is required by the new patient privacy regulations issued by ***the United States Department of Health and Human Services*** ("HHS"), and describes how your medical information may be used or disclosed, and how you gain access to your medical information.

Your protected medical information (I.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses, and demographic data) may be used by us in one or more of the following respects:

- To other health care providers (I.e. orthodontist, periodontist, endodontist, oral surgeon, prosthodontist, pedodontist, etc.) in connection with our rendering dental treatment to you;
- To third party payers or spouses (I.e. insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account
- To certifying licensing, and accrediting bodies (I.e. state boards, etc.) in connection with obtaining certification, licensing, or accreditation;
- Internally, to all staff members who have any role in your treatment, and/or
- To other patients and third parties who may overhear conversations about your treatment, scheduling etc.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information
- Receive an accounting of certain disclosures made by us of your protected health information; and
- You may file a complaint with the HHS Secretary as to any violation by us of your privacy rights, which must be filed within 180 days of violation.

We have the following duties under the privacy rules:

- To only utilize your protected health information as set forth in the attached consent and/or authorization;
- ***To obtain your written consent to use your protected health information for treatment, payment or healthcare operations, and to refuse treatment if you refuse to sign the consent;***
- To obtain your written authorization to use your protected patient information for any purpose other than treatment, payment, or healthcare operations;
- To use reasonable efforts to limit the amount of protected health information that is used, disclosed, or requested to the minimum degree necessary where such information is used, disclosed, or requested for purposes other than treatment; and
- To obtain satisfactory assurances from our business associates who render services to our office that your protected health information will be safeguarded by them.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclose of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete;
- Provide an atmosphere that is totally free of the possibility that your protected health information may be overheard by other patients and third parties.

If you have any questions about the information in the Notice, please let us know. Thank you.

NAME:_____ DATE: _____

SIGNATURE: _____

AMBIDA
FAMILY DENTISTRY, P.C.

OFFICE POLICIES & INFORMATION ABOUT YOUR INSURANCE

Our office is happy to help file your dental insurance claims to receive dental benefits with which you and your employer are paying premiums. Dental benefit plans can vary from company to company with different procedures which have a benefit or a "percentage" of a benefit. Your insurance plan will only pay what it allows for each service, regardless of what the actual fee may be. Deductibles and co-payments are typically built into most plans and their required payment is strictly regulated by state law. Both our office and you, as the policy beneficiary, can be prosecuted if deductibles and co-payments are not collected. Your employee benefits director at your company or place of work can usually help you become familiar with your plan and its restrictions, and our office will assist you in maximizing your benefits.

INSURANCE AND PAYMENT POLICIES:

FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF SERVICE. For treatment involving fees above $500.00, special financial arrangements, including Care Credit, may be discussed with our insurance coordinators.

For patients with dental insurance:

We will file your claim for you at no charge, however, we require that your deductions and your estimated portions (20%-60%) be paid on the day of treatment. Although we gladly file dental insurance claims, *any and all account balances are ultimately your responsibility.*

All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.

Please note for your convenience, we do accept VISA, MasterCard, and Care Credit as well as checks and cash.

OFFICE POLICIES:

Please provide our office with necessary information concerning your insurance. This generally includes your birth date and SSN, or and even the birth date and SSN of the policy holder. This is how the insurance companies have you listed.

Understand that your plan is a contract between you, your employer, and the insurance carrier. Our office will do all we can to facilitate claims payment, but Ambida Family Dentistry does not have the power to make your insurance company pay.

If insurance does not pay on a claim, we will file the claim again. However, any account balance not paid by your insurance company after two (2) billing attempts is ***your responsibility.***

Your appointment time is set aside for you. We ask for courtesy to the Doctor and to the other patients that you keep your scheduled appointments. If you must change your appointment, we would appreciate a 48-hour notice. More than one cancellation or failure in less than this time frame will result in a broken appointment charge of $25.00. Thank you for your cooperation.

We realize that many families are in a state of change. **The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred. Your portion will be requested on the same day treatment was done**.

We will be fair in working out special finances with you, but please also be fair to us with your commitments. **A 1.5% finance charge will be assessed monthly on all overdue balances.**

CONSENT:

I have read and understand the above information. If any changes occur, i.e. address, phone number, insurance information, etc., I will inform Ambida Family Dentistry, P.C. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes release of dental records to my insurance company.

DATE: _____Signature_____ (patient, parent, guardian)

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GENERAL DENTISTRY INFORMED CONSENT

1. DENTAL TREATMENT: I understand that I may have any of the following treatment done which include but are not limited to: fillings, bridges, crowns, extractions, root canals, dentures, x-rays, cleanings, scaling and root planings, implant restorations, etc.

2. MEDICATIONS AND PRESCRIPTIONS: I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. *In very rare instances*, local anesthesia (a shot) can cause parasthesia (discomfort in the nerves of the mouth, jaw etc.) or even permanent anesthesia.

3. CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while treating the teeth which were not discovered during the examination, I.e. root canal therapy following routine restorative procedures. I give my permission to the dentist to make any and all changes and additions as necessary for the best of my care.

4. DENTAL INSURANCE: I understand that ***it is my responsibility to have the correct dental insurance information.*** In understand that I need to inform Ambida Family Dentistry, P.C. ***of any changes to my insurance.*** In understand that Ambida Family Dentistry, P.C. will submit claims as a ***courtesy*** to me, again provided that I give the complete information necessary for these claims.

5. I understand that dentistry is *not an exact science and* that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

I hereby authorize Dr. Ambida and the dental auxiliaries to proceed and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on the unforeseen or undiagnosable circumstances that may arise during the course of treatment. ***I understand that regardless of any dental insurance coverage I may have***, ***I am responsible for payment of dental fees.*** I agree to pay any attorney' fees, collection fees, or court costs that may incur to satisfy this obligation. I understand that this agreement is to verify that I want treatment done at Ambida Family Dentistry, P.C. and it is not limited to only what was stated previously.

Patient Name:_____Date:_____

Signature:_____Date:_____

Guardian if minor:_____Date:_____

Print guardian's name:_____Date:_____

Ambida Family Dentistry

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____