spring creek dental PLLC

DRS. KAINES & COSPER

Welcome To Our Office

The staff of Spring Creek Dental would like to thank you for selecting our office to care for your dental needs. Our goals are to provide each patient with the highest quality dental care in a gentle, efficient, and pleasant manner; and to effectively encourage prevention of future dental problems.

We are here to serve our patients! We appreciate your comments and suggestions regarding our treatment, office procedures and staff. **Welcome!**

Office Hours

Our office hours are arranged to provide you with a variety of appointment options. The office is staffed according to the following schedule:

Monday	8:00am-6:00pm
Tuesday	8:00am-6:00pm
Wednesday	8:00am-5:00pm
Thursday	8:00am-5:00pm
Friday	8:00am-2:00pm

First Visit

Generally, the first visit will include a thorough examination with necessary x-rays for proper diagnosis followed by a consultation of your dental needs (unless you have a particular dental problem requiring immediate attention). Treatment costs will be discussed. Your periodontal health will be assessed and a separate appointment will be schedule for your dental cleaning.

Please complete both pages of the health questionnaire, consent form, payment policy form, and HIPPA (privacy policies) form and bring them with you to your first visit. Also, so we may assist you in filing any insurance claims (if you have dental insurance), **please bring your dental insurance card and completed signed forms.**

spring creek dental PLLC
DRS. KAINES & COSPER

JOEL KAINES, DDS
LINDSEY COSPER, DDS

WWW.MYDENTISTFORTCOLLINS.COM
Tel: (970) 482-8883

2001 S. SHIELDS ST. BLDG C1
FORT COLLINS, CO 80526

PATIENT INFORMATION

Date: ☐NEW PATIENT ☐UPDATE

Patient:

LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: Patient SSN:

Address:

ADDRESS LINE 1

CITY ST ZIP CODE

E-Mail:

HOME:
CELL:
WORK:

How did you hear about our office?

EMPLOYMENT INFORMATION

Employer: Occupation:

INSURANCE INFORMATION

Subscriber:

LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

SECONDARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: Treatment Type:

☐Y☐N Are you currently having dental discomfort? If yes, explain:
☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain:
☐Y☐N Any injuries to mouth/teeth/head? If yes, explain:
☐Y☐N Are your teeth sensitive to cold, hot, sweets, or pressure?
☐Y☐N Orthodontic appliances (braces) now or in the past?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Is your mouth dry?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N
☐Y☐N Do you have any clicking, popping, or discomfort in the jaw?
☐Y☐N Do you have sores or ulcers in your mouth?

What is the reason for your dental visit today?

Is there anything you would like to change about your smile?

spring creek dental PLLC
DRS. KAINES & COSPER

JOEL KAINES, DDS
LINDSEY COSPER, DDS

WWW.MYDENTISTFORTCOLLINS.COM
Tel: (970) 482-8883

2001 S. SHIELDS ST. BLDG C1
FORT COLLINS, CO 80526

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____

Clinic/Facility: City/State/Zip:

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now? _____
☐Y☐N Any serious illnesses/surgeries? _____
☐Y☐N Use tobacco in any form? If Yes, Type: _____
☐Y☐N Do you drink alcoholic beverages?
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint (hip, knee, shoulder)? Date:_____
☐Y☐N Are you taking, or have taken, any diet drugs such as Pondimin, Redux, or fen-phen?

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: _____

- Are you taking or scheduled to begin taking alendronate (Fosamax) or risendronate (Actonel) for osteoporosis or Paget's disease? ☐Y☐N
- Since 2001, were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer? ☐Y☐N
  Date Treatment Began: _____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ABNORMAL BLEEDING	☐CANCER/MALIGNANCY	☐HEART DISEASE	☐RESPIRATORY DISEASE
☐ACID REFLUX/HEARTBURN	☐CARDIOVASCULAR DISEASE	☐HEART MURMUR	☐RHEUMATIC HEAR DISEASE
☐AIDS/HIV	☐CHEST PAINS	☐HEPATITIS	☐RHEUMATIC FEVER
☐ANEMIA	☐CHRONIC PAIN	☐HIGH BLOOD PRESSURE	☐RHEUMATOID ARTHRITIS
☐ANGINA	☐CONGENITAL HEART DEFECTS	☐KIDNEY DISEASE	☐SINUS PROBLEMS
☐ANOREXIA/BULIMIA	☐CONGESTIVE HEART FAILURE	☐LIVER PROBLEMS	☐SLEEP DISORDER
☐ANXIETY	☐DAMAGED HEART VALVES	☐LOW BLOOD PRESSURE	☐STROKE
☐ARTERIOSCLEROSIS	☐DIABETES TYPE:_____	☐MIGRAINES	☐SYSTEMIC LUPUS ERYTHEMATOSUS
☐ARTIFICIAL HEART VALVE	☐DIZZINESS/FAINTING	☐MITRAL VALVE PROLAPSE	☐THYROID CONDITION
☐ARTHRITIS	☐EMPHYSEMA	☐MONONUCLEOSIS	☐TUBERCULOSIS
☐ASTHMA	☐EPILEPSY/SEIZURES	☐OSTEOPOROSIS	☐ULCERS
☐AUTOIMMUNE DISEASE	☐EXCESSIVE URINATION	☐PACEMAKER	☐WEIGHT LOSS (RAPID)
☐BLEEDING DISORDER/HEMOPHILIA	☐GASTROINTESTINAL DISEASE	☐PERSISTENT SWOLLEN GLAND(NECK)	☐OTHER – PLEASE LIST:
☐BLOOD TRANSFUSION YEAR:	☐GLAUCOMA	☐PSYCHIATRIC TREATMENT	
☐BRONCHITIS	☐HEART ATTACK	☐RADIATION/CHEMOTHERAPY	_____

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ASPIRIN	☐CODEINE	☐FOOD	☐ANIMALS
☐ANESTHETIC – LOCAL	☐DAIRY	☐METAL SENSITIVITY	☐SULFA DRUGS
☐BARBITURATES	☐LATEX	☐IODINE	☐PENICILLIN/OTHER ANTIBIOTICS
☐OTHER – PLEASE LIST:			

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS	☐ANTIHISTAMINES/ALLERGY	☐DAILY ASPIRIN	☐BLOOD PRESSURE MEDICATIONS
☐BLOOD THINNERS	☐CANCER/CHEMO MEDICATIONS	☐CORTISONE/STEROIDS	☐HEART MEDICATION/DIGITALIS
☐INSULIN	☐NITROGLYCERIN	☐ORAL CONTRACEPTIVES	☐OSTEOPOROSIS MEDICATIONS
☐OTHER DIABETIC MEDICATIONS	☐RECREATIONAL DRUGS	☐THYROID MEDICATIONS	☐TRANQUILIZERS
☐OTHER (PLEASE LIST BELOW)			

DRUG NAME	DOSAGE	REASON PRESCRIBED

Patient's Signature:_____ Date:_____

spring creek dental PLLC

DRS. KAINES & COSPER

OFFICE PAYMENT POLICY

In order to control costs, **payment is required at the time that services are performed.** Since we do not carry account balances past 30 days, we offer Care Credit (interest free credit company we partner with) and we also accept all major credit cards including Visa, Discover, Master Card, and American Express.

Your insurance contract is made between you and your insurance company. Insurance policies often do not cover 100% of the billed amount for dental procedures. Insurance companies have their own fee schedules in which their payment is based upon. Payment of your account is your responsibility.

As a courtesy, we will file on all insurance companies for you. Every effort is made to get an accurate estimate from your insurance company prior to your appointment and our front office staff will always give you a copy of your estimated portion prior to scheduling. We ask that you pay your portion whether it is for a cleaning or for restorative work at the time of service. If there is a difference after your insurance pays their portion, we will either send you a statement or a refund.

If you have any questions regarding your treatment or payment options please call us during our business hours.

As a courtesy to our other patients, we require 48 hours or 2 business days' notice for the cancellation of any appointment so that we may offer that appointment to another patient. A fee of $50 per hour of time may be assessed to your account if sufficient notice is not given.

_____ _____

Signature Date

spring creek dental PLLC
DRS. KAINES & COSPER

REMAINING BALANCE DEBIT AUTHORIZATION

I, _____ authorize Spring Creek Dental PLLC to auto debit my credit card for any remaining balances less than $100 after insurance has paid on my or my family's claims.

I understand that I will be notified prior to charges being posted.

_____

Patient Printed Name

_____

Patient Signature

_____

Date

_____

Card Number

_____

Card Type (Visa/MC, etc.)

_____

Exp. Date

_____

Security Code

_____

Billing Address for Credit Card (Street Address)

_____

ZIP Code

spring creek dental PLLC
DRS. KAINES & COSPER

GENERAL CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile, and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence in social interactions that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or Chemical Reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long-term Numbness (par aesthesia).** Local anesthetic, or its administration, while almost always adequate to follow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or Joint Tenderness.** Holding one's mouth open can result in muscle or jaw joint tenderness, or jaw tenderness or in a predisposed patient precipitate a TMJ disorder.
4. **Sensitivity in Teeth or Gums, Infection, or Bleeding.**
5. **Swallowing or Inhaling Small Objects.**

While we follow procedural guidelines that most often lead to clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statement on this page:

_____ _____
Patient's Signature Date

_____ _____
Parent's Signature (if minor patient) Date

spring creek dental PLLC
DRS. KAINES & COSPER

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

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 and acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify) _____

I authorize the following person(s) below to have full access to my dental records:

_____
Name and Address

_____ _____
Signature Date

NOTICE OF PRIVACY PRACTICES

Spring Creek Dental PLLC
Dr. Joel Kaines & Dr. Lindsey Cosper

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. The Privacy of your health information is important to us.***

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. This Notice takes effect immediately and will remain in effect until we replace it. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

Uses and Disclosures of Health Information

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operation: Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To Your Family & Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment for your best interest in allowing a person to pick up dental supplies, x-rays or other similar forms of health care and information.

Marketing Health-Related Services: We will not use your health information for marketing without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patients' Rights

You have the right to look at, or get copies of your health information, with limited exception. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. You have the right to request that we amend your health information. We may deny your request under certain circumstances. We support your right to the privacy of your health information. If you are concerned that we may have violated your privacy rights, please contact our office in writing.