Mirage Dental
85 Rio Grande Dr.
Castle Rock, CO 80104

(720)733-3440

frontdesk@miragedentalassociates.com
www.miragedentalassociates.com

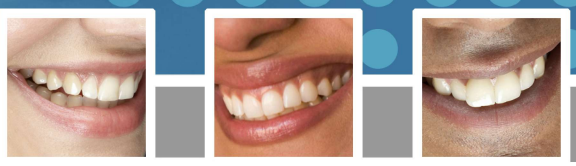


Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

In an emergency who should be notified? Please enter Name and Phone number below:

_____

Whom may we thank for inviting you to our practice?

_____

We enjoy giving our patients gifts. How do you like to be gifted? (Gift Card, Credit on account, items?)

_____

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your immediate concern?

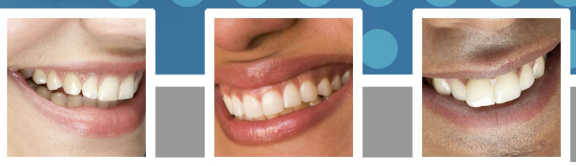
_____

What would you like to change about your smile or what other services would you like information on?

_____

Mirage Dental
85 Rio Grande Dr.
Castle Rock, CO 80104

(720)733-3440
frontdesk@miragedentalassociates.com
www.miragedentalassociates.com



Name of Insured: _____ (Last) _____ (First) _____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Social Security Number, Member ID, or Subscriber ID of Insurance Subscriber

* _____

Birthdate of Insurance Subscriber

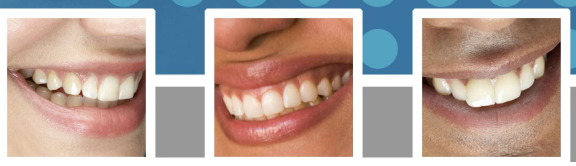
_____

☐ By checking this box, I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all changes whether or not paid by insurance.

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

☐ Alcohol/Drug Abuse	☐ Allergies	☐ Anemia
☐ Arthritis	☐ Artificial Joints	☐ Aspirin
☐ Asthma	☐ Blood Disease	☐ Cancer
☐ Codeine Allergy	☐ Diabetes	☐ Dizziness
☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting
☐ Glaucoma	☐ Growths	☐ Hay Fever
☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur
☐ Hepatitis	☐ Herpes/blisters	☐ High Blood Pressure
☐ HIV	☐ HIV	☐ Jaundice
☐ Kidney Disease	☐ Latex Allergy	☐ Liver Disease



- [ ] Mental Disorders
- [ ] Mitral Valve Prolaps
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Penicillin Allergy
- [ ] Percocet Allergy
- [ ] Pre Med
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Sulfa Allergy
- [ ] Thyroid
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

List all medications, supplements, and/or vitamins being taken currently:

* [ ] By checking this box, I acknowledge that above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.We require at least a 24 hour notice to cancel or reschedule an appointment. I understand and agree to a charge of $50 for all missed appointments, or apppointments cancelled with less than a 24 hour notice.

* [ ] By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.

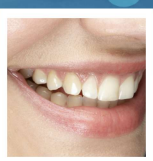
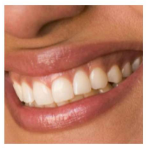
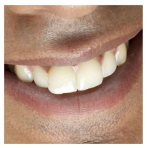
Oral Cancer Screening

* [ ] Although oral cancer screenings are encouraged by the American Dental Association and an insurance code exists for billing, this enhanced exam with the IdentafiT may not be covered by your insurance. The fee for this procedure is normally $35.00; if your insurance does not cover it, we do this at no cost to you, our valued patient.
Yes. I authorize the dental professionals of this office to perform an oral cancer screening using the IdentafiT. I realize that no screening result can guarantee that oral cancer will never occur. Furthermore, I understand that if areas of suspicion are detected, diagnostic tests may be needed to confirm or dismiss the presence of oral cancer.

Mirage Dental
85 Rio Grande Dr.
Castle Rock, CO 80104

(720)733-3440

frontdesk@miragedentalassociates.com
www.miragedentalassociates.com

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

Insurance Billing

* ☐ While we do bill to insurance companies as a courtesy to our patient's, insurance may not cover certain procedures or amounts. Even if insurance does not cover these procedures, if a patient's benefits do not allow coverage, or should a patient receive an offer for free services (these services are free to the patient, insurance will still be charged) these procedure codes will be billed to the patient's insurance provider for proper documentation.

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice website with my ID and password.

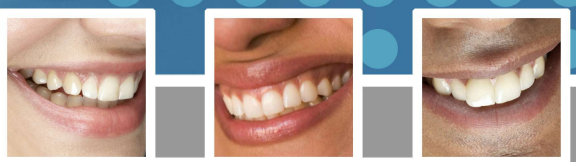
I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice cannot and does not assume any respoinsibility for my use or misuse of patient information or other information transmitted, monitored, stored, uploaded, or received using the site or the services.

* ☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Mirage Dental
85 Rio Grande Dr.
Castle Rock, CO 80104

(720)733-3440

frontdesk@miragedentalassociates.com
www.miragedentalassociates.com



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 dug 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 inappopriate 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.

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Prescription Drug Monitoring Form.

Signature of patient, parent or guardian (responsible party):

Signature: _____

Date: _____

Response Date: _____