WEST LAKE
DENTAL

2502 Abarr Dr. Loveland CO 80538 • Phone 970-669-1444 • Fax 970-669-1445

Welcome to West Lake Dental! We are delighted that you have chosen our office to care for your dental needs and we look forward to meeting you! Please find the enclosed new patient paperwork for you to fill out and bring to your appointment. Below is a quick introduction to our doctor & team.

Andy Maples, DDS Dr. Andy Maples is a graduate of Creighton University School of Dentistry. He received several awards while at Creighton- The Inaugural Dr. Simpson Award of Excellence in Aesthetic Restorative Dentistry, The Department of General Dentistry Award and The American Association of Oral Maxillofacial Surgery Award. Dr. Andy grew up in Colorado and graduated from Colorado State University. He enjoys hiking fourteeners, competing in triathlons, and spending time with his wife Lauren and two kids Collin and Mia

* Fellow of the Misch Implant Institue
* Fellow of the International Congress of Oral Implantogists (ICOI)
* Member of the American Dental Association (ADA)
* Member of the Colorado Dental Association (CDA)
* Member of the Larimer County Dental Society (LCDS)
* Member of the Academy of General Dentistry
* Invisalign certified provider
* Inman Aligner certified provider

Our team of front office managers, assistants & hygienists are here to provide you with the highest level of care. We look forward to meeting you!

WEST LAKE DENTAL

PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____

RESPONSIBLE PARTY _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____

CELL PHONE (_____) _____ TEXT REMINDER: Yes _____ No_____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

EMAIL ADDRESS _____ EMAIL REMINDER: Yes_____No____

SINGLE _____ MARRIED _____ NAME OF SPOUSE _____

EMERGENCY CONTACT _____ PHONE (_____) _____

EMPLOYER _____ OCCUPATION _____

REFERRED BY: _____

PREFERRED PHARMACY (NAME, PHONE, LOCATION): _____

_____

INSURANCE INFORMATION

INSURED'S NAME _____

INSURED'S DOB _____

MEMBER ID # _____ GROUP # _____

INSURED'S EMPLOYER _____ WORK PHONE (_____) _____

INSURANCE CO. _____ INSURANCE PHONE (_____) _____

INSURANCE ADDRESS _____

The undersigned herby authorizes the release of any information relating to claims for benefits submitted on behalf of me and/or my dependents (i.e. personal information, x-rays, progress notes….) until I have submitted a written request disallowing this. I further agree and acknowledge that my signature on this document authorizes my signature on each and every claim to be submitted for me and/or my dependents and that this signature will bind me as though the undersigned had personally signed the particular claim. This signature will authorize the insurance company to send their payment directly to West Lake Dental. I understand that even though I may have insurance coverage the contract I have is between the insurance company and me. Submission of insurance is a benefit to my family and me. Anything not paid including, but not limited to, the difference in fees between the insurance company and our office is to be paid immediately to West Lake Dental.

_____

AUTHORIZED SIGNATURE DATE

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver, _____)		
☐ latex _____		
☐ nuts _____		
☐ fruit _____		
☐ milk _____		
☐ red dye _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) ___	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) __	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g. "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment or antidepressant medication _____	☐	☐
45. concentration problems or ADD/ADHD diagnosis _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)**

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____ /____ /____ Date of most recent x-rays ___ /____ /____

Date of most recent treatment (other than a cleaning) ____ /____ /____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE		
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34. Have you ever whitened (bleached) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

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.

OUR LEGAL DUTY

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. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice please contact us using the information listed at the end of this Notice.

USES OF DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use or disclose your health information to obtain payment for services we provide to you.
Healthcare Operation: We may use and disclose your health information for treatment, payment or healthcare operations; you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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, but only if you agree that we may do so.
Person Involved in Care: We may use and disclose your health information to notify, or assist in the notification of (including identifying family member, your personal representative or another person responsible for your care), your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information used 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 and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, medical supplies, x-rays, or other similar terms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your information when we are required to do so by law.
Uses or Neglect: We may disclose your health information appropriately 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 of safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

WEST LAKE
DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OR PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgement **

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

_____

(Please 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)

_____

WEST LAKE
DENTAL

Financial Guidelines

Thank you for choosing our practice for all your dental care needs. We are committed to providing you with the highest quality dental care using only the best materials and technology available on the market today. We are also committed to providing you with the up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. These financial guidelines are intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient. Not with your insurance company. Our office is not a party to that contract and we have no say in the coverage your insurance provides.

As a courtesy to you, we will help you process all your insurance claims. We will estimate your portion due at the time of service to the best of our knowledge. We will then bill your insurance and any unpaid balance will be your responsibility. It is also your responsibility to keep us updated on your current insurance information.

Payment is due at the time services are provided. Our office accepts cash, personal checks, Master Card, Visa, American Express, and Discover. Outside financing is available through Lending Club upon request and approval. Please see the following page for additional details about the payment options our office offers.

Regarding divorce and family billing: This office is not a party to any divorce decrees. We may bill the person designated as the responsible party as a courtesy to you. However, please understand that our legal right is to bill the party (or guardian) that is present for treatment. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account.

If you have any questions regarding our financial guidelines, please ask. We are committed to providing you with a positive and supportive experience in dental care.

_____

Print name

_____ _____

Signature Date

Notice of Financial Options

We understand that our patients have a variety of needs in financing their dental treatment, and we want to support you in finding the best option for your needs. Below you will find the options our practice provides for financial arrangements. **Please note that any estimate of insurance coverage and patient responsibility is ONLY an estimate and is not a guarantee of payment from your insurance company.**

Payment Options

1. **Down Payment Plan:**

   For any treatment of $500 or more, patients may make a down payment of 40% of the total cost of treatment on the day treatment is provided. After this initial payment, the remaining balance is to be paid over the next three months (90 days) in monthly payments. No interest is applied to the 60% balance.

2. **Cash Discount for Payment in Full:**

   We offer a courtesy discount of 5% on any patient payment of $500 or more, as long as payment is made in full prior to the scheduled treatment. Payment must be in the form of cash or check, as we cannot apply the discount to any payments made by card (debit/credit/HSA) due to credit card processing fees.

3. **Outside Financing through Lending Club (needs to be approved at least 1 week prior to treatment):**

   Lending Club is a personal loan company that offers a variety of plans with flexible terms and the ability to finance amounts up to $50,000. Please see the included brochure for details about Lending Club. You can apply for financing via their website – lendingclub.com/dental – and work with them directly to determine the best plan for your needs. Please note there is a minimum purchase of $500 for a 6-month plan and $999 for a 12-month plan, so if your treatment is less than $500 this option will not be available to you.

Please sign below to confirm that you received this statement of financial options. This does not obligate you to a specific payment plan at this time.

_____ _____

Signature Date

Missed appointment policy

We want to thank you for choosing us as your health care provider. In order to give you and all our patients the best possible care, we request that you review our policy regarding missed appointments.

A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24-hours.

Please remember that we have reserved appointment times especially for you. Therefore, we request at least a 24-hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients.

If you are unable to keep your scheduled appointment time, please call our office at least 24-hours in advance in order to avoid a missed appointment fee. This charge is not covered by insurance. Your phone call is critical in helping us provide continuous care to all of our valued patients.

If you fail to give us a notice of your missed appointment, you will be charged a $75 missed appointment fee.

I have read and understand the policy stated above:

_____

Print Name

_____ _____

Signature Date

WEST LAKE DENTAL

2502 Abarr Dr. Loveland CO 80538 • Phone 970-669-1444 • Fax 970-669-1445

AUTHORIZATION TO RELEASE AND RECEIVE INFORMATION

Client Name: _____

Date of Birth: _____

I understand that the purpose of this release is to allow communication between West Lake Dental and other care providers or significant individuals relevant to myself/my child/my family. By signing this release, I authorize West Lake Dental to release the following information:

INFORMATION TO BE RELEASED:

___ Copy of complete dental chart

___ Copy of dental x-rays

___ All treatment rendered in this office or by this doctor

___ *Limited to treatment dates & for conditions described below:

_____

___ Other (describe - e.g., models): _____

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

___ Transfer of Records ___ Second Opinion ___ Claim evaluation

___ Scheduling or billing conversations with a family member ___ Other (describe): _____

I authorize West Lake Dental to release this information to the following individuals:

1) _____
(Name of person or office / Phone / Email)

2) _____
(Name of person or office / Phone / Email)

3) _____
(Name of person or office / Phone / Email)

☐ By checking this box, I also authorize the above individuals/offices to release any protected health information relevant to my dental care back to West Lake Dental/Dr. Andy Maples.

I understand and voluntarily agree to authorize the release of information. I understand my consent can be revoked at any time and will expire in one year from the date of my signature. I understand that this consent may include disclosure of alcohol and drug abuse records protected by federal regulation.

_____ _____

Patient Signature Date

Parent Signature (if patient is a minor) Date

Revised August 2021