Angela Osborn DDS
9105 Kimmer Dr.
Lone Tree, CO 80124
303.799.9993

Patient Information

Patient Name: ______________________

Date: ______________________

Address: ______________________
Street Address
____
City State Zip

How did you hear of our office? ______________________

Sex: F ☐ M ☐ Age ____ Birthdate ______

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Patient SS# (conf) ______________________

Occupation ______________________

Employer ______________________

Employer Address ______________________

Employer Phone ______________________

Spouse's Name ______________________

Birthdate ______ SS# ______

Occupation ______________________

Spouse's Employer ______________________

Dental Insurance

Name of who is responsible for the account? ______________________

Relationship to patient, if not the patient? ______________________

Insurance Company ______________________

Group # ______________________

Is the patient covered by additional insurance ☐ Yes ☐ No

Subscriber's Name ______________________

Birthdate ______ SS# (confidental) ______

Relationship to Patient ______________________

Insurance Company ______________________

Group # ______________________

Assignment and Release

I, the undersigned certify that I (or my dependant) have insurance coverage with ______________________
I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature ______________________

Relationship ______________________ Date ______

Phone Numbers

Home ______ Work ______ Ext. ____ Email ______________________

Best time and place to reach you? ______________________ What number best for appointment reminder? ______________________

In case of EMERGENCY, Contact

Name ______________________ Relationship ______________________

Home Phone ______________________ Work Phone ______________________

Dental History

Reason for today's visit ______________________
____

Previous Dentist ______________________

City / State ______________________

Date of last dental visit ______________________

Date of last dental X-Rays ______________________

Please mark Yes or No to indicate if you have had any of the following:

Condition	Yes	No
Persistent Bad Breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Broken fillings	☐ Yes	☐ No
Burning Sensation on tongue	☐ Yes	☐ No
Chew on one side of Mouth	☐ Yes	☐ No
Cigarette, pipe or cigar smoking	☐ Yes	☐ No
Clicking or popping Jaw	☐ Yes	☐ No
Dry Mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No
Foreign objects (ex.lip/tongue rings)	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose Teeth	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth Pain, brushing	☐ Yes	☐ No
Ortho treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in mouth	☐ Yes	☐ No
How often do you floss?	__ / day	__ / wk
How often do you brush?	__ / day	__ / wk

Health History

Physician's Name ______________________ Date of last visit: ______________

Please mark either "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No	Comments
Aids	☐ Yes	☐ No	
Anemia	☐ Yes	☐ No	
Arteriosclerosis	☐ Yes	☐ No	
Arthritis, Rheumatism	☐ Yes	☐ No	
Artificial Heart Valves	☐ Yes	☐ No	
Artificial Joints	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	
Back Problems	☐ Yes	☐ No	
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	
Blood Disease	☐ Yes	☐ No	
Blood Transfusion	☐ Yes	☐ No	
Botox in the last week	☐ Yes	☐ No	
Breast Implant Surgery	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
Chemical Dependency	☐ Yes	☐ No	
Chemotherapy	☐ Yes	☐ No	
Circulatory Problems	☐ Yes	☐ No	
Congenital Heart Lesions	☐ Yes	☐ No	
Cortisone Treatments	☐ Yes	☐ No	
Cough, persistent or bloody	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Emphysema	☐ Yes	☐ No	
Do you wear contacts?	☐ Yes	☐ No	
Developmental disability	☐ Yes	☐ No	
Eating Disorder	☐ Yes	☐ No	
Epilepsy	☐ Yes	☐ No	
Fainting or Dizziness	☐ Yes	☐ No	
Fybromyalgia	☐ Yes	☐ No	
Glaucoma	☐ Yes	☐ No	
Headaches	☐ Yes	☐ No	
Heart Murmur	☐ Yes	☐ No	
Heart Pacemaker	☐ Yes	☐ No	
Heart Problems	☐ Yes	☐ No	
Hepatitis	☐ Yes	☐ No	
Type			
Herpes	☐ Yes	☐ No	

Condition	Yes	No	Comments
High Blood Pressure	☐ Yes	☐ No	
HIV Positive	☐ Yes	☐ No	
Jaundice	☐ Yes	☐ No	
Jaw Pain	☐ Yes	☐ No	
Kidney Disease	☐ Yes	☐ No	
Liver Disease	☐ Yes	☐ No	
Low Blood Pressure	☐ Yes	☐ No	
Mitral Valve Prolapse	☐ Yes	☐ No	
Multiple Sclerosis	☐ Yes	☐ No	
Nervous Problems	☐ Yes	☐ No	
Osteoporosis	☐ Yes	☐ No	
Women - Are you Pregnant?	☐ Yes	☐ No	
Due Date:			
Are you Nursing?	☐ Yes	☐	
Psychiatric Care	☐ Yes	☐ No	
Radiation Treatment	☐ Yes	☐ No	
Respiratory Disease	☐ Yes	☐ No	
Rheumatic Fever	☐ Yes	☐ No	
Scarlet Fever	☐ Yes	☐ No	
Seizure	☐ Yes	☐ No	
Shortness of Breath	☐ Yes	☐ No	
Sinus Trouble	☐ Yes	☐ No	
Skin Rash	☐ Yes	☐ No	
Special Diet	☐ Yes	☐ No	
Substance Abuse	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	
Swelling of Feet of Ankles	☐ Yes	☐ No	
Swollen Neck Glands	☐ Yes	☐ No	
Thyroid Problems	☐ Yes	☐ No	
Tonsillitis	☐ Yes	☐ No	
Tuberculosis	☐ Yes	☐ No	
Tumor/growth on head/neck	☐ Yes	☐ No	
Ulcer	☐ Yes	☐ No	
Venereal Disease	☐ Yes	☐ No	
Weight Loss, unexplained	☐ Yes	☐ No	
Sleep Apnea	☐ Yes	☐ No	

MEDICATIONS

List any medications you are currently taking:

Pharmacy Name ______________________

Pharmacy Location ______________________

Pharmacy Phone ______________________

ALLERGIES

- ☐ Aspirin
- ☐ Local Anesthetic
- ☐ Barbituates
- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Iodine
- ☐ Other __________
- ☐ Latex

ANGELA M. OSBORN D.D.S., P.C
9105 KIMMER DRIVE
LONE TREE, CO 80124
PHONE 303.799.9993
FAX 303.799.9998

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 and social interaction 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 (paresthesia).** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, Muscle permanent numbness.
3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw joint 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 which most often lead to a 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 NAME please print	Date
______________________________	______________
Patient's signature	Date
______________________________	______________
Guardian's signature (if minor patient)	Date

Financial Policy

One important aspect of optimal patient care is to have an agreement as to financial responsibility to avoid any misunderstandings and to ensure timely payment for services. Angela M. Osborn D.D.S, P.C. policy requires that all patients sign the Authorization and Consent for Treatment Form prior to receiving dental services. The form confirms that patients understand services being provided are necessary and appropriate. The form also advises patients of their complete financial responsibility for all services received without regard to insurance eligibility or coverage determinations.

Payment Responsibility

Patients or their legal representative are ultimately responsible for all charges for services rendered. Payment is expected at time of service for all charges owed for the current visit as well as any prior balance. We will securely store your credit card information. We will charge your card for the balance you owe as soon as your insurance company informs us of the patient's responsibility. This payment policy benefits you by reducing administrative burden and settling your portion of the bill in a timely manner.

Outstanding Balances

If the credit card on file does not get approved, any outstanding balance that is due from the patient is payable in full upon receipt of statement. In the event a patient presents for an office visit and has an outstanding balance, a request for payment will be made. Statements are generated on a twenty-eight (28) day cycle. Patients who fail to respond to statements will be placed into collection status. Patients with an outstanding balance for more than (90) days may be referred to an outside collection agency and will be charged a $20 collection fee in addition to the balance owed. A patient with unpaid delinquent accounts or accounts which have been written off to bad debt may not receive additional scheduled services.

I have read and understand the above statements page:

______________________________	_______________
Patient's NAME (please print)	Date
______________________________	_______________
Patient's signature	Date
______________________________	_______________
Guardian's signature (if minor patient)	Date

Cancellation Policy for appointments:

For all appointments we require 3 business days notification. If you are more then 10 minutes late you will be asked to reschedule your appointment and will be charged a fee(this counts as a no show or late cancellation).

If the required notification is not given to the office, a fee will be charged to the patient.

I have read and understand the statement on this page:

______________________________	_______________
Patient's NAME (please print)	Date
______________________________	_______________
Patient's signature	Date
______________________________	_______________
Guardian's signature (if minor patient)	Date

TEXT MESSAGING AUTHORIZATION

I authorize the use of text messaging for appointment reminders.

(Standard text messaging rates apply)

I have read and understand the statement on this page:

______________________________	_______________
Patient's NAME (please print)	Date
______________________________	_______________
Patient's signature	Date
______________________________	_______________
Guardian's signature (if minor patient)	Date

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 web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

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 RESPONSIBILITY 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 and understand the statement on this page:

______________________________	_______________
Patient's NAME (please print)	Date
______________________________	_______________
Patient's signature	Date
______________________________	_______________
Guardian's signature (if minor patient)	Date

Angela M. Osborn D.D.S.
9105 Kimmer Drive
Lone Tree, Co 80124
303.799.9993 fax 303.799.9998
www.osborndds.com

Patient Introduction to Laser bacterial reduction consent

We are constantly learning and striving to advance the standard of patient care in our office. As such we have recently added a new procedure to your routine cleaning care to help fight periodontal disease.

Periodontal disease affects approximately 80% of adults and is growing epidemic in our society. Understanding of this disease has increased greatly over the last few years. We now know that Periodontal Disease is a bacterial infection in the pockets around teeth. As such, we **now** not only treat perio with removal of mechanical irritants and diseases tissue (your normal cleaning) but are also addressing the underlying infection that causes it. With that thought in mind we recommend that all of our patient have their teeth decontaminated prior to cleaning appointments for three major reasons.

1. **To reduce or eliminate bacteremias**. During the normal cleaning process most patients will have some areas that may bleed, this allows bacteria that are present in all our mouths to flood into the bloodstream and sometimes settle in weakened areas of our body, such as a damaged heart valve or artificial knee or hip etc. We pre-medicate those patients that we know have a heart condition or artificial joints with antibiotics so that these bacteria can't cause harm to these areas. Latest research shows that these oral pathogens have now been linked to a number of other diseases such as cardiovascular disease, rheumatoid arthritis, low birth weight babies, diabetes, etc. Needless to say anything that we can do to reduce or eliminate these bacteremias is a positive for our patients.
2. **To prevent cross contamination** of infections in on area of your mouth to other areas. Decontamination minimizes the chance that we may inadvertently pick up bacterial infection in one area of your mouth and move it to others.
3. **To kill periodontal disease bacteria** and stop their infections before they cause physical destruction to loss of attachment around your teeth.

The laser decontamination process is painless and normally takes about 5-10 minutes. We **highly** recommend that you take advantage of this service as part of your routine and periodontal maintenance appointment.

Laser decontamination is $40 and is NOT covered by insurance. Unfortunately insurance coverage is almost always behind the leading edge in high tech health care.

Please ask our hygienist if you have any questions regarding this treatment. Please sign below if it's ok to perform this service for you on ALL your future hygiene appointments.

Patient name (print) ________________________________

Sign ____Date_________________

Please read and sign the following if you wish to **decline** the recommended treatment.
I fully realize that this recommended treatment is needed. However, at this time, I cannot arrange for the needed treatment and release the Doctor and his/her staff completely of any responsibility.

Patient name (print) ________________________________

Sign ____Date_________________

Witness ____ Date ________________

ANGELA M. OSBORN D.D.S, P.C.
9105 KIMMER DRIVE
LONE TREE, CO 80124
P:303-799-9993
F:303-799-9998

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you, the patient, significant rights to understand and control how your health information is used.

HIPAA provides penalties for covered entities, including our Practice, that misuse "protected health information" (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes effect on 05/01/2016, and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

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

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and

receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. 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, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office, or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. 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 obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

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

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests. You have the right to request such an accounting in an electronic format.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency circumstances.

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request, in writing, that we amend your PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail, you are entitled to receive a copy in written form.

Notice of Privacy Practices

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Brittany at her information below:
Contact Person: Brittany
Telephone: 303.799.9993 Fax: 303.799.9998
E-mail: brittany@osborndds.com
Address: 9105 Kimmer Drive Lone Tree, CO 80124

______________________________ ____________________
Patient Name (please print) Date

____
Patient Signature

______________________________ _______________
Guardian's signature (if minor patient) Date

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: Brittany

Address: 9105 Kimmer Drive

Telephone: 303-799-9993

Fax: 303-799-9998

Email: Brittany@osborndds.com

Angela M. Osborn DDS

COSMETIC ASSESSMENT FORM:

Patient name: ______________________________ Date: _____________

Please consider each statement carefully and circle YES or NO. The doctor and members of the dental team will discuss your responses with you in confidence.

YES NO 1.) I am concerned about the appearance of my teeth or my smile.

YES NO 2.) I am concerned about the whiteness/lack of whiteness of one or more of my teeth.

YES NO 3.) I am concerned about the position or angle of one or more of my teeth.
YES NO 4.) I am concerned about the shape of one or more of my teeth.
YES NO 5.) In social situations, I am sometimes embarrassed by my teeth or smile.
YES NO 6.) There are some things about my upper front teeth that I would like to change.

YES NO 7.) There are some things about my lower front teeth that I would like to change.

YES NO 8.) I have old fillings or previous dental treatment that is no longer satisfactory to me.

YES NO 9.) I am missing one or more of my teeth.

YES NO 10.) I am interested in learning more about esthetic (cosmetic) dentistry.

YES NO 11.) Have you ever had BOTOX®, Kybella, Juvederm or cosmetic injectable treatments?
If yes, When? ________________

YES NO 12.) Are you interested in learning more about BOTOX®, Kybella, Juvederm and cosmetic injectable treatments?

Patient Photo Consent Form

By initializing the space below, I, ___________________________________(name of patient), do hereby authorize Angela M. Osborn, DDS to use and/or disclose of the photos.

I understand any and all reproductions of materials including my image or personal testimony obtained remains the property, solely and completely of Angela M. Osborn, DDS, to but used exclusively for the promotion of Angela M. Osborn, DDS including, but not limited to, on its website and social media.

I understand that by signing below I am voiding any previous election to “opt out” of releasing my photo for the purpose(s) outlined above.

I fully understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

Finally, I do understand that I may revoke this authorization any time, provided that I do so in writing. I also understand that information released between the effective date of this authorization and the date of revocation may still be used in the public domain.

Print Patient(s) Name_______________________________________Date_________________

Signature of Patient or Patient’s Representative_______________________________________

Print Name of Personal Representative (if applicable)___________________________________

Relationship to Patient____