Patient Information

Patient Name: _____ Preferred Name:_____
Last First MI

Social Security #:_____ Date of Birth:_____

Please Circle One: Married Single Child Other

Address: _____

City: _____Zip Code: _____

Mobile: _____ Home:_____ Work:_____

Email: _____

Health Information

Date of Last Dental Visit:_____ Reason for Today's Visit:_____

Have you ever had the following:

O AIDS	O Glaucoma	O Currently Pregnant Due Date: _____	O Ulcers
O Anemia	O Growths		O Venereal Disease
O Arthritis	O Hay Fever		O Codeine Allergy
O Artificial Joints	O Head Injuries		O Penicillin Allergy
O Asthma	O Heart Disease	O Radiation Treatment	O Osteoporosis
O Bisphosphonates	O Heart Murmur	O Respiratory Problems	
O Blood Disease	O Hepatitis	O Rheumatic Fever	O Other Medical Conditions:_____
O Cancer	O High Blood Pressure	O Rheumatism	_____
O Congenital Heart Condition	O Jaundice	O Sinus Problems	O Other Allergies:_____
O Diabetes	O Kidney Disease	O Stomach Problems	_____ **Medications:**
O Dizziness	O Liver Disease	O Stroke	_____
O Epilepsy	O Mental Disorders	O Tuberculosis	_____
O Excessive Bleeding	O Nervous Disorders	O Tumors	_____
O Fainting	O Pacemaker	O Heart Valve Replacement	If additional space is needed please write on back or email list.

Do you use tobacco? O Yes O No If yes, how often? _____

Do you use marijuana? O Yes O No If yes, how often? _____

Have you ever had complications following dental treatment? O Yes O No If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years?

O Yes O No If yes, please explain: _____

Are you now under the care of a physician? O Yes O No

If yes, please explain: _____

Physician's Name:_____Physician's Phone Number: _____

Do you have any health problems that need further clarification? If yes, please explain :

_____

I acknowledge that it is my responsibility to update my doctors with any changes that occur. I attest that the information that I have provided is true and correct.

_____ _____

Signature of Patient, Parent, or Guardian **Date:**

How did you hear about our office?

O Patient, friend _____ O Patient, family _____

O Insurance Company O Yelp O Facebook O NextDoor
O Google O School O Dental /Ortho Office _____

O Other _____

DR. CAMERON AUGER & ASSOCIATES
19245 E SMOKY HILL ROAD, SUITE B
CENTENNIAL, CO 80015
PHONE: 303-680-3308 FAX: 303-680-3928

Billing and Collection Policies

We bill insurance companies for you as a courtesy. Our billing your insurance does not guarantee payments. Insurance companies may deny payment due to waiting periods, frequency limitations from previous work done on a tooth (ex. five-year crown rule) or area of the mouth, or for procedures not covered due to insurance riders in your plan. **Our office is unable to verify all possible exceptions to your insurance plan.**

We appreciate co-payments at the time of service. Our computer program makes an estimate based on past billings and information provided by the insurance company. Any fees not covered by the co-payment will be billed to the patient. Any overpayments will be returned to the patient promptly. **Any estimate given by Dr. Auger, associate dentists or a staff member is only an estimate** based on information given by **your insurance company**. Information from insurance is given in general categories and is not specific to every procedure. **Estimates are not a guarantee of payment** by your insurance company. As a patient, you are welcome to verify directly with your insurance company or request a pre-authorization be sent.

As the patient, you have the responsibility for payment for all services provided. As the patient, you are responsible for co-payments associated for all procedures provided. We send out monthly statements. If not paid promptly, the account will be turned over to our collection agency. By signing below, you authorize this provider and its employees, agents, and assignees to contact you via e-mail and text messaging, and to your cellular devices. ***I understand that responsibility for payment of medical services in this office for myself and my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly).***

We understand patients' schedules occasionally change, and you will need to reschedule or cancel an appointment. Please contact the office at least 48 business hours prior to your scheduled appointment to cancel or reschedule the appointment to avoid a missed appointment fee.

Please also confirm your appointments at least one day in advance. Any appointments not confirmed by this time may be cancelled by us to accommodate other patients.

We do not place amalgam (silver) fillings. Some insurance companies will downgrade payments for posterior composite (tooth-colored) restorations. If your insurance company does this, you will be responsible for paying the difference in price.

Please call with any questions regarding your account. We will answer questions as promptly as possible.

DATE: _____

Printed Name:

_____ _____

Last, First, Middle Initial Signature of patient or guardian

DR. CAMERON AUGER & ASSOCIATES
19245 E SMOKY HILL ROAD, SUITE B, CENTENNIAL, CO 80015
PHONE: 303-680-3308 FAX: 303-680-3928

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 medication may trigger allergic or sensitivity reactions.
2. Long-term numbness (parasthesia). Local anesthetic, or its administration, while almost always adequate to allow 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 in a predisposed patient, precipitate a TMJ disorder.
4. Sensitivity in teeth or gums, infection, or bleeding.
5. Swallowing or in inhaling small objects.

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

Please note: We do not cover amalgam restorations. Any subsequent charges for resin restorations not covered by the insurance company will be the responsibility of the patient.

If it is determined that you need deep cleaning (Scaling and Root Planing), you may have an insurance co-payment. Perio Maintenance cleanings following deep cleanings may also incur additional cost depending on your insurance. Due to your periodontal health, you may need more than two cleanings a year.

I have read and understand the statements on this page.

_____ _____
Patient's signature Date

_____ _____
Parent's signature (if patient is a minor) Date

NOTICE OF PRIVACY PRACTICES

Effective Date: [02/16/2026]

This Notice describes how medical and dental information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

OUR RESPONSIBILITIES

We are required by law to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of the Notice currently in effect

HOW WE MAY USE AND DISCLOSE YOUR INFORMATION

For Treatment

We may use or share your health information to provide, coordinate, or manage your dental care.

Example: Sharing X-rays with a specialist or another dentist involved in your care.

For Payment

We may use or share your information to bill and receive payment for services.

Example: Submitting claims to insurance or contacting you about balances.

For Health Care Operations

We may use or share your information to run our practice, improve quality, and train staff.

Example: Internal audits, training, and quality improvement.

OTHER PERMITTED USES AND DISCLOSURES

We may also use or share your information:

- As required by law
- For public health activities
- To prevent or reduce a serious threat to health or safety
- For workers' compensation or law enforcement purposes, as allowed by law

SPECIAL PROTECTIONS FOR CERTAIN INFORMATION (Part 2 / SUD Records)

If our practice maintains records related to **substance use disorder (SUD) treatment,** those records receive **additional protections under federal law.**

- If such information is received under a **general authorization** that permits use and disclosure for treatment, payment, or health care operations, as described above, we will use the information for some or all of those purposes.
- If such information is received under a **specific authorization,** we will use and disclose only as allowed under that specific authorization.
- Such information **will not be shared without your written authorization,** except as permitted or required by law.
- Once shared with your written consent, the *information* ***may be redisclosed by HIPAA entities,*** in accordance with HIPAA regulations.
- Such information, if de-identified, may be disclosed to public health authorities **without your written consent.**

YOUR RIGHTS

You have the right to:

✓ Get a Copy of Your Records

You may request access to our copies of your dental records. We may charge a reasonable fee.

✓ Request Corrections

If you believe information is incorrect or incomplete, you may request an amendment.

✓ Request Confidential Communications

You can ask us to contact you in a specific way (e.g., phone instead of mail).

✓ Request Restrictions

You may request limits on how your information is used or shared. We are not required to agree in all cases.

✓ Get a List of Disclosures

You can request a list of certain disclosures we have made.

✓ Receive a Paper Copy of This Notice

You may request a paper copy at any time.

OUR USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

We will **not** use or disclose your information for purposes such as marketing or sharing with third parties **without your written authorization,** unless permitted by law.

You may revoke an authorization at any time in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice and make the revised Notice effective for information we already have. The updated Notice will be posted in our office and on our website (if applicable).

COMPLAINTS

If you believe your privacy rights have been violated, you may:

- File a complaint with our office
- File a complaint with the U.S. Department of Health and Human Services

You will **not** be retaliated against for filing a complaint.

CONTACT INFORMATION

Privacy Officer: Human Resources
Phone: (480) 626-4118
Email: HR@signaturedentalpartners.com
Office Address: 19245 E Smoky Hill Rd, Suite B, Centennial, CO 80015

Acknowledgment of Receipt (Recommended)

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient Name: _____

Signature: _____
Date: _____